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JANUARY, 1975
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Hawaii Medical Journal

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Both often



- Predominant psychoneurotic anxiety

- Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor

neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive dis-

orders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anti-convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent

in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium[®] (diazepam) 2-mg, 5-mg, 10-mg tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of child-bearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle

spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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The new nutritional margarine labels have a message about you.

INFORMATION ON FAT AND CHOLESTEROL CONTENT IS PROVIDED FOR INDIVIDUALS WHO, ON THE ADVICE OF A PHYSICIAN, ARE MODIFYING THEIR TOTAL DIETARY INTAKE OF FAT AND CHOLESTEROL.

Mandatory nutritional statement on the back of all margarine labels.

Saffola® wants you to get the rest of the message.

MAZOLA

Nutrition Information Per Serving

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Servings per container	32
Calories	100
Protein	0 grams
Carbohydrate	0 grams
Fat	11 grams
*Percent of calories from fat	99%
*Polyunsaturated	3 grams
*Saturated	2 grams
*Cholesterol	0 (0 per 100 grams)
Sodium	120 milligrams (865 mg/100 gm)

Percentage of U.S. recommended daily allowances (U.S. RDA)

Vitamin A 10%

Contains less than 2 percent of the U.S. RDA of protein, Vitamin C, thiamine, riboflavin, niacin, Calcium, and iron

*Information on fat and cholesterol content is provided for individuals who, on the advice of a physician, are modifying their total dietary intake of fat and cholesterol

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Nutrition Information Per Serving

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Servings per container	32 (per pound container)
Calories	100
Protein	0 (not a significant source of protein)
Carbohydrate	0
Fat	11 grams
Percent of calories from fat	over 99%
**Polyunsaturated	3 grams
**Saturated	2 grams
**Cholesterol	0 (0 per 100 grams)

Percentage of U.S. recommended daily allowances (U.S. RDA)*

Vitamin A 10%

Vitamin D 15%

*Contains less than 2 percent of the U.S. RDA of Vitamin C, thiamine, riboflavin, niacin, calcium, and iron.

**Information on fat and cholesterol content is provided for individuals who, on the advice of a physician, are modifying their total dietary intake of fat and cholesterol

SAFFOLA

Nutrition Information Per Serving

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Servings per container	32 (per pound container)
Calories	100
Protein	0
Carbohydrate	0
Fat	11 grams
Percent of calories from fats	100%
Polyunsaturated	5 grams
Saturated	2 grams
Contains no cholesterol	

Information on fat and cholesterol content is provided for individuals who, on the advice of a physician, are modifying their total dietary intake of fat and cholesterol

Percentage of U.S. recommended daily allowances (U.S. RDA)

Vitamin A 10%

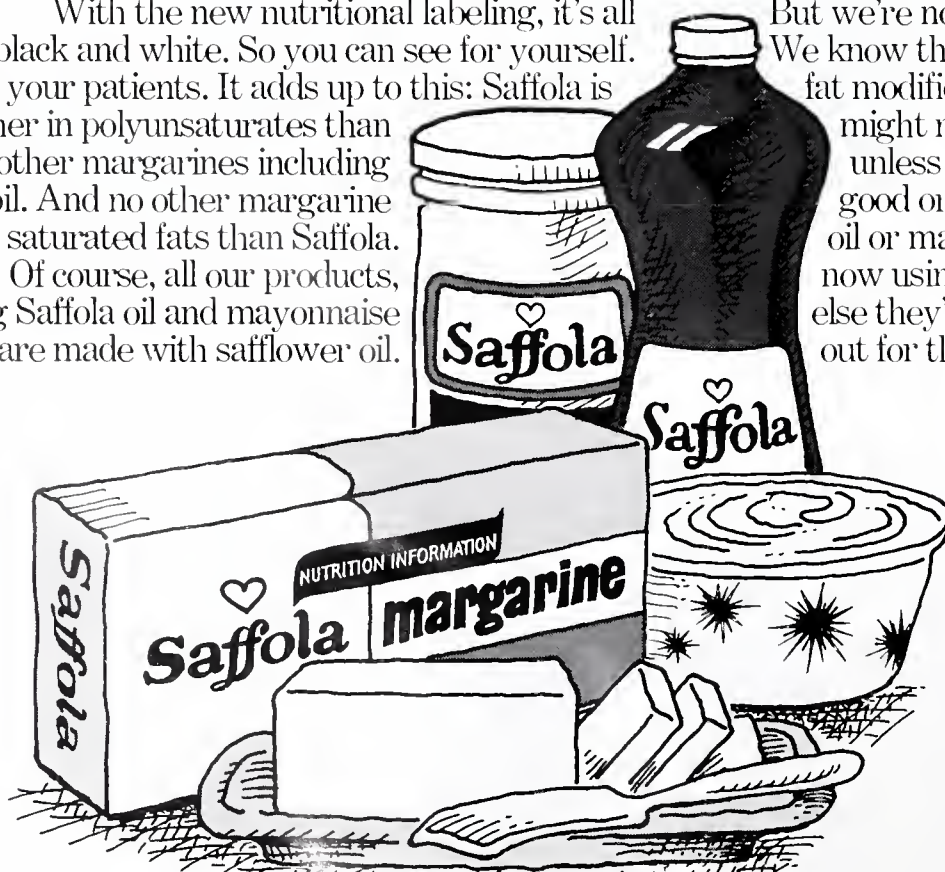
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When diarrhea has his number...



Lomotil puts him back in the game.

Physicians and patients both want prompt control of the symptoms of diarrhea. A rapid, uncontrolled loss of fluids and electrolytes can cause a medical crisis, particularly in children, and in patients who are seriously ill, or in people who are badly undernourished.

Lomotil usually stops diarrhea promptly. This rapid action halts the emergency aspect of diarrhea

and is comforting and reassuring to the patient. Electrolyte and fluid losses can be corrected while the specific cause of the diarrhea is being determined. If an infective agent is the cause, appropriate antibiotic therapy should be given along with Lomotil.

Lomotil has few side effects, and those that do occur are generally mild.

Lomotil[®]
TABLETS/LIQUID

Each tablet and each 5 ml. of liquid contain:
diphenoxylate hydrochloride 2.5 mg.
(Warning: May be habit forming)
atropine sulfate 0.025 mg.

Usually stops diarrhea promptly.

IMPORTANT INFORMATION: This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: Lomotil is contraindicated in children less than 2 years old. Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of 1/2 ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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Medical Department, Box 5110,
Chicago, Illinois 60680

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MAKANA FOUNDATION

The Role of the Detail Man

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

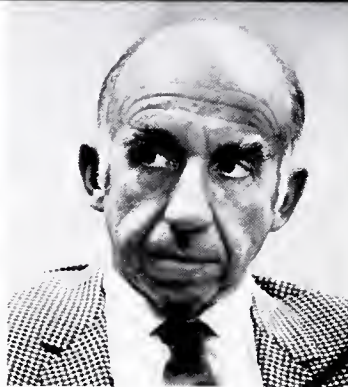
Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.

Dr. Willard Gobbell
Family Physician
Encino, California



Dr. Jeremiah Stamler
Chairman
Department of Community
Health and Preventive
Medicine, and Dingman
Professor of Cardiology
Northwestern University
Medical School



"In the total picture of dealing with health problems in this country, there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihood on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be — and at times actually are — disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets — some of it scientifically sound and therefore truly useful — as well as some excellent films produced by the pharmaceutical industry. When they function in this

Opinion
&
Dialogue

Is He a Source of Information?

Yes, with certain reservations. The average sales representative is a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. I go without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility

of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce — information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone

in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love — they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and

thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public — *i.e.*, the patients — will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that informa-

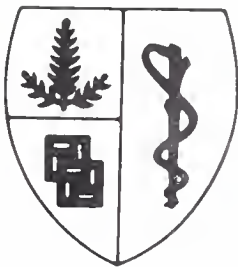
tion must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical
Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005





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General lectures will cover: a review of chemistry and physics for clinicians, chemical bonds of biological importance, subatomic particles, correlation of cell structure and function, the structure and function of proteins, sugars and lipids, the structure of nucleic acids, DNA synthesis, expression of genetic information, regulation of gene expression, evolution of proteins, carbohydrate and fat metabolism, bioenergetics, neuroendocrine relationships, neurobiology—structure and development, neurobiology—function, neurobiology—a cellular approach to the nervous system, mutagenic hazards.

Elective sessions will include: the biology of water, structure of matter, bacterial antibiotic resistance, salt and water, interferon, blood coagulation, gastrointestinal immunity, energy supply and the design of the brain, tumor virus, genetics and disease, rheumatic disorders, organ morphogenesis, nutrition, enzymes and their actions, prostaglandins, atherosclerosis, hypertension, renin, and aldosterone, chromosomes and disease, mechanisms of immunity, genetics—problems and opportunities, nerve growth, hormones and their actions, molecular mechanisms of drug actions, biological membranes.

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PREMARIN (Conjugated Estrogens
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For more than thirty years it
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complex in the proportions found
in its natural source. And for more
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quality for you and your patients.

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BRIEF SUMMARY

(For full prescribing information, see package circular.)

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(Conjugated Estrogens Tablets, U.S.P.)

Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications for use as follows:

Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus. **"Probably" effective:** For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding. **Warnings:** Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism).

If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.

Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens

should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.

Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:

nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating

breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)

breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum

loss of libido and gynecomastia in males
edema

aggravation of migraine headaches
change in body weight (increase, decrease)
headache

allergic rash
hepatic cutaneous porphyria becoming manifest
Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (e.g. osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

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Plan and Organization for Utilization Review At Queen's Medical Center

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The complexion of medical care delivery has undergone considerable change in the last ten years, particularly in the conduct and study concerning the quality of medical care. The greatest innovation is the change from a passive role of the medical audit and tissue function to a more aggressive assessment of the quality of care delivered.

A data collecting system, the PAS MAP, made it possible to assess the level of care rendered by practicing physicians rapidly along prescribed parameters. TITLE XVIII and XIX laws required a review of all patient care in acute care facilities with regard to justification of hospitalization, both concurrently and retrospectively, using the length of stay disease guideline studies derived from the PAS System, as well as the "level of care" concept.

With emphasis on utilization review and quality assurance programs, the medical records of patients became extremely important as sources of data. Major changes in documentation appeared, the latest being the Problem Oriented Medical Record.

It became apparent, as these programs developed, that a better review organization of physicians' performance was necessary. In 1972 an effort was made to combine the functions of utilization review and quality care. This organization was called, the Professional Activity Review (PAR). Its role was to insure the delivery of medical service at the optimum level, in terms of efficiency, effectiveness economy and humanity.

Optimum care would not be synonymous with extravagant waste of hospital services. The utilization review process would be the mechanism by which this would be assured. The utilization review process would also assure that the quality

of medical care would not be compromised.

The PAR Committee would be chaired by the chief of staff-elect, and comprised of the assistant chiefs of each department and service, plus five members at large, including representation from the laboratory and radiology departments, and from the Infection and the Transfusion Committees.

The PAR Committee was to meet monthly to review the activity of the previous month, and discuss and decide on any major problem and policy. Each department and service, in turn, would have its own PAR subcommittee chaired by the assistant chief, and would meet at least once a month to discuss quality review studies and utilization review.

In order to facilitate quality review studies, three teams of assistants, each consisting of a QAC (Quality Assurance Coordinator) and an abstractor, would be assigned to each PAR subcommittee to help in obtaining raw data for interpretation by the physicians involved in the PAR activity.

The utilization review system of the PAR organization was also to include the concept of a team for each ward, consisting of a UR physician, the head nurse and a utilization review assistant. The team assigned on any given nursing unit would be totally responsible for daily reviews of patients. Patients found to be appropriately hospitalized within guideline days of stay would be referred to the PAR subcommittee for a retrospective study and review of their stay. Patients who were found not to be appropriately managed would be referred to the UR physician for his review and recommendations. Those cases reviewed would also be referred to the PAR subcommittee for retrospective review and study later.

Evaluating the success of this method of peer review requires assessing:

1. physician acceptance of his role as a reviewer
2. physician acceptance of being reviewed
3. timely attention to review duties
4. acceptance of care and treatment standards as they develop and evolve
5. head nurse participation in the peer review process
6. multiple disciplines involved in the delivery of health care systems

Professional Activities Review Committee

The Professional Activities Review Committee coordinates all of the review facilities of the medical-dental staff. It reports directly to the Medical Advisory Committee, through its chairman. It relates to the clinical departments through the assistant chiefs. Its functions are as follows:

- a. Maintain a continuing appraisal of medical care as practiced in the hospital.
- b. Initiate audit studies as recommended by the departmental PAR subcommittees.
- c. Direct, coordinate and provide follow-up to the work of the departmental PAR subcommittees and receive, at monthly intervals, reports from these subcommittees.
- d. Submit periodic reports to the Board of Directors through the Medical Advisory Committee with recommendation for improvements in medical care standards.
- e. Oversee the proper utilization of the resources and facilities of the hospital.

Further, no physician with financial interest in the Queen's Medical Center is to serve on the Utilization Review Committee.

The associate administrator of Queen's Medical Center is a member of the PAR Committee. Other non-voting members are representatives from the Title XVIII and XIX and V intermediaries: the Hawaii Medical Service Association, the Aetna insurance company, and the Medicare program of the Department of Health, Hawaii State.

Professional Activities Review Subcommittees

The Assistant Chiefs of all clinical services and/or departments are the Chairmen of the Departmental Professional Activities Review Subcommittees. The functions of these subcommittees are as follows:

Audit Review Functions:

1. Improve the quality of medical care of patients by the review and continuing analy-

sis of all documented medical cases and by education;

2. Study and report on cases referred to these subcommittees;
3. Maintain a record of each physician whose cases were studied by these subcommittees. The management of such cases shall be classified as acceptable or not acceptable.
4. Each subcommittee shall report to the Professional Activities Review Committee at least once a month. The report shall be based on the correlation of the clinical diagnoses and pathological diagnoses where appropriate, and on the acceptability of the medical care given, including psychiatric care.
5. The report shall be based on the correlation of pre-operative, post-operative and pathological diagnoses and on the acceptability of surgical procedures, including those procedures in which no tissue was removed.

Quality Assurance

The Board of Directors of The Queen's Medical Center has delegated to Medical-Dental Staff the responsibility for assuring quality medical care to patients of The Queen's Medical Center. This responsibility is specifically vested with the Professional Activities Review Committee under the chairmanship of the Chief of Staff-Elect. The Committee, in turn, assigns to each of its subcommittees, audit and utilization functions.

In the summer of 1973, the utilization review program at The Queen's Medical Center was revised to include:

1. Preadmission criteria;
2. Concurrent review of care; and
3. Retrospective sampling review of care.

These requirements are similar in intent to the requirements of Medicare utilization which is concerned with:

1. Necessity of inpatient admission;
2. Appropriate length of stay;
3. Timely and appropriate use of X-ray, Laboratory, and other diagnostic and therapeutic facilities.

While these latter requirements pertain only to Medicare patients, The Queen's Medical Center applies utilization reviews to all of its patients.

Utilization Review

The Quality Assurance and Utilization Review Plan of The Queen's Medical Center requires that the care of all patients shall be reviewed daily beginning on the day of admission. The daily review shall be done by physician

members of the PAR subcommittees assigned to this duty on a rotation basis. All active and courtesy medical staff members of The Queen's Medical Center who admit patients are required to act as utilization review physicians. Each department and service of the Medical-Dental Staff is required to provide a monthly listing of reviewers. From lists provided by the assistant chiefs of departments and services, the Utilization Review Clerk notifies physician reviewers of their scheduled rotation time and orientation meeting.

Lists of reviewers are circulated monthly to each nursing unit, computer center, chairman of the PAR Committee, Medical Records Department. To facilitate patient care reviews with a minimum of administrative work for the reviewers, the assistance of the head nurse of each floor and Medical Records staff are an integral part of the concurrent review process. The head nurse on each nursing unit initiates the daily review of patients and discusses with the physician reviewer of the need for a closer review of a patient's care and stay.

The utilization review assistant keeps the concurrent review process current by coordinating all the necessary inclusions of data and information required to keep daily patient reviews up to date and current. She works closely with a utilization review clerk in coordinating these efforts.

Daily statistics tabulated include:

- 1. Number of reviews by head nurse by floor, service and length of stay percentile.
- 2. Total number of chart reviews done by floor, service and physician.
- 3. R (-)* followed daily.
- 4. Denials logged separately.

Monthly statistics tabulated include:

- 1. Failure of review within 72 hours and the reasons.
- 2. Incomplete R (-) Reviews within 48 hours by floor, service and the reasons.
- 3. Percentage of reviews to admission.
- 4. Percentage of denials to admission.
- 5. Average stay of in-house denials.
- 6. Denials by service.
- 7. Comparison on denials by in-house and HMSA pre-denials
 - a. number of cases—total
 - b. days denied
 - c. average stay of denials.
- 8. Physician's profile on R (-) and Denials, participation in U.R.

The utilization review assistant assigned from the Medical Records Department coordinates all data and information from the attending physician, head nurse, physician reviewer, medical

records, keeping data and information on the units always current and up to date. A utilization review clerk works with the utilization review assistant in helping the physicians to carry out this responsibility. The type of review with which the utilization review assistant is involved in the review of each case of continuous extended duration. A daily concurrent review is made to assure the necessary and appropriate continued use of the facility by extended duration patients.

The daily census sheet and medical records are reviewed to decide whether further stay of specific patients is necessary and appropriate. Extended duration cases are involved in the review process, according to the PAS length of stay for the western region of the United States, as well as according to the discretion of the head nurse, who may indicate that a review be done whenever she feels that the level of acute care is questionable. The federal program requires that payment for certain services may be made to the hospital when there is a physician's certification that the services were needed. The utilization review assistant is responsible for obtaining the required physician's certification and recertification statements.

The UR assistant activities, likewise, include keeping a particular file of all patients in the house, deleting discharges, filing new admissions, noting transfers. She assigns length of stay days according to the designated percentile (PAS Hospitals) to each new admission and sends hospital days in duplicate for each patient to the computer center. She makes daily rounds and records changes in diagnoses and operations on the census sheet which she feeds to the computer. She records each review done, as well as reviewers' decisions. She stamps charts for utilization review and certification and makes appropriate notifications concerning decisions. She keeps a monthly listing of reviews performed each day.

This review is coordinated by means of a daily current census and information sheet (See Table I) on which pertinent, up-to-date information on patients on each nursing unit may be found. The sheet contains the name of the patient, his room and bed number, his physician, his diagnosis, and/or surgical procedure, admission date and time, age, sex, days in the hospital, and length-of-stay guide days. The latter are the 50% and 75% guideline days of PAS experience for the western region states. These are based on admitting diagnosis and can be changed as subsequent diagnosis or surgical procedure may indicate. There are two other columns on the sheet, one to indicate a review is made and/or request-

*Glossary—Table II

TABLE 1.—Daily current census and information report
QUEEN'S MEDICAL CENTER
CENSUS PRE-LIST REPORT

Reviewer: W. Sage
Nursing Unit: Pauahi VII

ROOM BED NO.	PT. NAME	PT. NO.	DR.'S NAME	DIAGNOSIS & PROCEDURE	ADM. DATE	ADM. TIME	AGE	SEX	DAYS IN	LENGTH OF STAY		M R	D
										50%	75%		
701	John Doe	799822	Joe Gannon	Rt. Inguinal Hernia 11/19 Rt. Inguinal Hernia Repair	11/18	12:40 PM	43	M	3	5	8	✓	
702	Mr. X	799823	J. Kildare	Rt. Colon Abscess 11/19 Drainage of Appendiceal Abscess, Control of Hemorrhage From Appendiceal Abscess	11/18	1:15 PM	55	M	3	7	12	✓	
705	Joy Blow	799838	Marcus Welby	Possible Subphenic Abscess	11/17	2:35 PM	68	F	4	1	3	X	✓
708	Sady Hawkins	799825	J. Kiley	Metastatic CA	11/10	9:00 AM	76	F	11	9	16	R+	✓
709	Roy Rogers	799820	J. Jones	Probable Overdose	11/15	1:55 AM	39	M	6	1	3	XR-15	

ed, the other for the reviewer to initial that a review has been made.

Requests for reviews may be made by the head nurse of a nursing unit at any time that the patient's condition may indicate. A review is also automatically flagged by the computer 24 hours before the expiration of the guideline days. The M.D. reviewer, in daily consultation with the head nurse, makes reviews as are indicated.

On making a review of a patient's care and treatment, the M.D. reviewer decides whether or not that care and stay are appropriate, being guided by standards of criteria developed by each PAR subcommittee of The Queen's Medical-Dental Staff. If a patient's care and stay is appropriate and within guideline days of stay, discharge from the hospital is routine. The pa-

tient's case is then referred to the appropriate PAR subcommittees for quality review studies on a retrospective random study basis.

If a request by the attending physician for an extended stay for his patient is approved, subsequent reviews by the M.D. reviewer are pre-arranged. After discharge, the patient's case is referred to the appropriate PAR subcommittee for a review of extended stay.

If a denial of continued hospitalization for a patient is imminent, the attending physician is given 48 hours to provide reasons for continued stay. When continued hospitalization is found to be inappropriate by the M.D. reviewer, the attending physician, the patient, the medicare or medicaid intermediaries are duly notified and at the expiration of 72 hours from notice, insurance benefits under Medicare or Medicaid will terminate. The success of the concurrent daily review of patient care and stay is dependent upon:

1. the expertise of the head nurse and her daily evaluation of the patients;
2. the disease criteria developed and established by the departments and services of the medical-dental staff of The Queen's Medical Center; and
3. disease guideline days developed by the PAR subcommittees;
4. upon those guideline days compiled nationally by the Professional Activities Studies (PAS) organization at Ann Arbor, Michigan; and

TABLE 2.—Glossary of utilization review symbols

- ✓ —no review requested (marked by head nurse)
- R —Review requested (marked by head nurse)
- R+ —decision by M.D. reviewer that hospital stay is appropriate (marked by reviewer)
- R(—) —M.D. reviewer is requesting additional information within 48 hours) from attending physician before completing review (marked by reviewer)
- D —continued hospital stay inappropriate (marked by reviewer)
- E —number of extended days requested by attending and granted by M.D. reviewer after review (recorded in LOS column 75%)
- ✓ —no review requested (marked by head nurse)
- R —Review requested (marked by head nurse)
- R+ —decision by M.D. reviewer that hospital stay is appropriate (marked by reviewer)

5. the expertise of the physician reviewer.

The concurrent utilization review process is concerned with:

1. Appropriateness of admission (1st review must be within 24 hours after admission);
2. Quality of ongoing medical treatment and care;
3. Appropriateness of current stay;
4. Proper utilization of facilities and services.

In order to accomplish the above purposes, statistics are provided as follows:

1. Number and percent of patients discharged on or before the 50th percentile;
2. patients discharged between the 50 and 75th percentile;
3. patients discharged after the 75th percentile;
4. patients discharged after the 75th percentile without review;
5. average length of stay; and
6. number of requests for extension made, approved and denied.

The concurrent utilization review process is designed to fulfill Medicare requirements of certification and recertification. However, in the interim we are adhering to the present procedure of certifying and recertifying by attending physician before the 12th and 18th day of hospitalization. These are documented in the patient's chart by an appropriate and timely stamp on the patient's progress sheet. The utilization review assistant sees to it that this requirement is kept current by the attending physician.

The utilization review assistant likewise sees to it that Medicaid requirements, forms and documentations are current and in order.

When a patient's continued hospitalization is deemed unnecessary by the physician reviewer, the utilization review assistant then processes denial notices to the following: (however she notifies the patient's family and physician by telephone before letters of notice are sent)

- a. Patient
- b. Attending Physician
- c. Intermediaries, Medicare or Medicaid
- d. Business services
- e. Patient relations coordinator
- f. Administration
- g. Patient's chart (to insure proper notification)

Quality Review Studies

The quality review studies program or medical care evaluation studies program at The Queen's Medical Center is carried on by the PAR sub-

committees. The subcommittees are assisted by a team of Quality Assurance Coordinators and Abstractors who are assigned to the following services:

TEAM I

Medicine
Psychiatry
General Practice
Cancer Committee
Transfusion Committee
Infection & Contagion

TEAM II

General Surgery
Urology
Thoracic & CVS
Plastic
Anesthesiology
Emergency Room Service

TEAM III

Ob-Gyn
Ophthalmology
Otolaryngology
Orthopedics
Neurosurgery
Dental

All charts are reviewed initially by the abstractors who assist the QAC by coding all charts, abstracting significant data for PAS/MAP reports, and referring all questionable cases to the QAC.

The QAC's work with the committee chairman in planning meetings, working up agendas and preparing studies, statistics and other materials for the committees to review and act upon. In conjunction with the U.R. Assistant, they prepare monthly U.R. statistics for each committee to evaluate its performance. They select charts not reviewed on the floor for a sampling review by the committee.

The role of the QAC's is to assist the committees in selecting, developing and revising disease criteria. They assist in the preparation of studies by abstracting pertinent information from charts and PAS/MAP reports. The results are tabulated for the committee to review and make judgements. They also perform special statistical studies requested by the committee.

Other functions of the QAC are:

1. Assist with the compilation of data for the physicians' profiles.
2. Assist with the development of new procedures and forms as requested by the Committees and suggest methods of improving the documentation of the care given the patient.

3. They keep the Committee informed of any changes in interpretation of or new laws which may affect their service or department.
4. Report on complications, deaths and normal tissue for review by the respective departments and specialty service committees. A record is kept in the minutes of chart number, physician number, summary of admission, the committee's decision as to whether the hospitalization and management were acceptable or unacceptable, and what action was taken.
5. Studies of Diagnoses and Procedures: Studies are made of a particular diagnosis, such as duodenal ulcer, or a special procedure such as electroshock therapy. Either a specified number of cases will be included in a study, or all relevant cases for a particular time period will be audited in order to

reveal patterns of care. The technique of quality assurance review is patterned after the JCAH guidelines.

The data for these studies is gotten whenever possible from the PAS/MAP reports. When needed, additional information is abstracted directly from the chart by Medical Records personnel.

Using the JCAH Retrospective Patient Care Audit Procedure, a summary of the abstracted information plus cases needing chart review is brought to the committee for analysis and determination of action to be taken.

6. Subcommittee proceedings are disseminated by mailings to staff members, verbal and written communication with individual physicians when indicated, reports to departmental staff meetings, the PAR committee, the Medical Advisory Committee and the Board of Directors.

A Survey for Intestinal Parasites in Oahu Schoolchildren

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NED H. WIEBENGA M.D., M.P.H.** , *Honolulu*

● *Intestinal parasitism is prevalent throughout the islands of the South Pacific. Although Hawaii shares with these islands the physical conditions conducive to parasite transmission, past surveys have shown¹ that due to a comparatively good hygienic level, the infestation rates are relatively low and largely confined to immigrant groups.*

The last survey for intestinal parasites in Hawaii was carried out by Ching² in 1960, when 1,195 stools were examined in Honolulu, along with 185 specimens from Hilo. She recorded a 12.25% positive rate for parasites and commensals, the majority of infections being in immigrants coming from endemic areas.

Since 1960, the pattern of migration into Hawaii has changed dramatically, with many more people now coming from tropical countries of the Pacific basin. In 1960 there were 3 immigrants from the Philippines, while in 1970 there were 6,426³.

The influx of infected individuals, whose cultural and hygienic practices are probably slow to change, could constitute a new reservoir of transmission. Intestinal parasitosis in immigrant children may cause school problems. For these reasons, it was felt that a new survey for intestinal parasites would be useful.

Young school children between kindergarten and third grade were selected as representing the best available 'sentinel' group. Several sites on Oahu were selected, to determine if any foci of infection and transmission exist.

Materials and Methods

Children from kindergarten to third grade in

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five Oahu Schools: Fern School (Kalihi), Waialua, Kahuku, Laie, and Waimanalo, were the subjects of this survey. Each child was given a stool cup and a questionnaire to be completed by the parent or guardian, as to the child's age, place of birth, length of residence in Hawaii and personal physician. The stool cups were collected next morning and taken to the Department of Tropical Medicine and Medical Microbiology laboratory at Leahi Hospital. The character of the specimen was noted and then examined microscopically for ova and parasites by direct smear and by zinc sulfate concentration.

Results

The results of the survey, summarized in Tables 1 and 2, indicate several aspects of intestinal parasitism of epidemiological interest, as well as some potential clinical problems that local physicians should be alert to. Table 1 shows there is a high prevalence of intestinal parasitism, particularly helminth infestations, in foreign-born school children. Immigrant children from Kalihi (Fern School) had a notably high rate, 43.4% being infested with one or more parasites. *Trichuris trichiura* was most commonly detected, though the majority affected seemed to have low worm burden. Polyparasitism was not as common as in endemic areas, more than one type of parasite being found in 12 of the 51 infested stools (23.5%). Multiple infestations mostly occurred in recent immigrants; the worm burden, as indicated by the number of ova in the standard direct smear, was usually moderate to high.

Although the sample is relatively small, there is persuasive evidence (Table 2) that, of the immigrant children examined, Samoans were most likely to be infested with one or more para-

TABLE 1.—The prevalence of intestinal parasites in U.S.-born and foreign-born school children from various localities on Oahu.

Number and (percent) Infections Found											
Elementary School	Number Examined	Total Infected	<i>Ascaris lumbricoides</i>	<i>Trichuris trichiura</i>	<i>Hook-worm</i>	<i>Strongy-loides stercoralis</i>	<i>Entameba histolytica</i>	<i>E. coli</i>	<i>E. limax</i>	<i>Iodameba butschlii</i>	<i>Giardia lamblia</i>
All Schools											
Total	390	51(13.1%)	11(2.8%)	29(7.4%)	8(2.1%)	1(0.2%)	1(0.2%)	3(0.8%)	1(0.2%)	1(0.2%)	16(4.1%)
Foreign Born	115	37(32.1%)	11(9.5%)	28(24.3%)	5(4.3%)	1(0.8%)	1(0.8%)	2(1.7%)	1(0.8%)	1(0.8%)	6(5.2%)
U.S. Born	275	14(5.1%)	0	1(0.4%)	3(1.1%)	0	0	1(0.4%)	0	0	10(3.6%)
Kalihi (Fern School)											
Total	116	27(23.3%)	9(7.8%)	18(15.5%)	5(4.2%)	1(0.9%)	1(0.9%)	2(1.7%)	1(0.9%)	1(0.9%)	5(4.3%)
Foreign Born	53	23(43.4%)	9(17.0%)	18(40.0%)	3(5.6%)	1(1.9%)	1(1.9%)	1(1.9%)	1(1.9%)	1(1.9%)	2(3.8%)
U.S. Born	63	4	0	0	2	0	0	1	0	0	3
Waialua											
Total	110	5(4.5%)	1(0.9%)	1(0.9%)	0	0	0	0	0	0	3(4.8%)
Foreign Born	25	4(16.0%)	1(4.0%)	1(4.0%)	0	0	0	0	0	0	3(2.7%)
U.S. Born	85	1(1.2%)	0	0	0	0	0	0	0	0	1(1.2%)
Kahuku											
Total	56	3(5.3%)	1(1.8%)	1(1.8%)	1(1.8%)	0	0	0	0	0	3(2.7%)
Foreign Born	7	1(14.3%)	1(14.3%)	1(14.3%)	1(14.3%)	0	0	0	0	0	0
U.S. Born	49	2(4.1%)	0	0	0	0	0	0	0	0	2(4.1%)
Laie											
Total	75	12(16.0%)	0	5(6.6%)	2(2.7%)	0	0	1(1.3%)	0	0	4(5.3%)
Foreign Born	22	5(22.7%)	0	4(18.2%)	1(4.5%)	0	0	0	0	0	0
U.S. Born	53	7(13.2%)	0	1(1.9%)	1(1.9%)	0	0	1(1.9%)	0	0	4(7.5%)
Waimanalo											
Total	33	4(12.1%)	0	4(12.1%)	0	0	0	0	0	0	2(6.1%)
Foreign Born	8	4(40.0%)	0	4(40.0%)	0	0	0	0	0	0	2(25.0%)
U.S. Born	25	0	0	0	0	0	0	0	0	0	0

TABLE 2.—The infection rate of intestinal parasites in foreign-born Oahu school children according to country of birth.

Number and (percent) Infections Found											
Place of Birth	Number Examined	Total Infected	<i>Ascaris lumbricoides</i>	<i>Trichuris trichiura</i>	<i>Hook-worm</i>	<i>Strongy-loides stercoralis</i>	<i>Entameba histolytica</i>	<i>E. coli</i>	<i>E. limax</i>	<i>Iodameba butschlii</i>	<i>Giardia lamblia</i>
Samoa	15	11(73.3%)	5(33.3%)	11(73.3%)	3(20.0%)	1(6.6%)	1(6.6%)	1(6.6%)	1(6.6%)	1(6.6%)	2(13.3%)
Tonga	8	3(37.5%)	0	3(37.5%)	0	0	0	0	0	0	0
Tahiti	1	0	0	0	0	0	0	0	0	0	0
New Zealand	6	1	0	0	1	0	0	0	0	0	0
Philippines	71	19(26.7%)	5(7.0%)	15(21.1%)	2(2.8%)	0	0	1(1.4%)	0	0	3(4.2%)
Vietnam	2	1	1	0	0	0	0	0	0	0	0
Okinawa	2	0	0	0	0	0	0	0	0	0	0
Japan	1	0	0	0	0	0	0	0	0	0	0
Korea	2	0	0	0	0	0	0	0	0	0	0
Taiwan	3	0	0	0	0	0	0	0	0	0	0
Puerto Rico	2	1	0	0	0	0	0	0	0	0	0
Peru	1	0	0	0	0	0	0	0	0	0	1
Germany	1	0	0	0	0	0	0	0	0	0	0

sites. Filipino children also showed a relatively high infestation rate. Most of the Filipino children had resided in Hawaii for several years, and in the absence of continuing reinfestation, they had probably lost short-lived parasites, such as *Ascaris lumbricoides*. Had they been examined shortly after entry into Hawaii, the infestation rate might have been quantitatively and qualitatively higher.

This survey indicates that transmission of intestinal helminths is not occurring to any great degree on Oahu. Nevertheless, that some transmission does take place is indicated by three cases of hookworm (2 in Kalihi and 1 in Laie) and one case of trichuris (Laie) in locally-born children.

Giardiasis occurred almost equally between U.S. born and foreign-born children. With a point prevalence result of almost 5%, the actual infestation rate would probably be significantly higher if serial stool specimens had been examined. Over half the stools in which *G. lamblia* was de-

tected were yellowish and fetid indicating the fat-malabsorption steatorrhea associated with this infection.

Pinworm (*Enterobius vermicularis*) infestation has not been reported here, since the stool examination is a poor diagnostic method. However, the presence of pinworm ova in the stools generally signifies a heavy infestation. A number of stools were positive for pinworm ova; four such positives from Waialua school children indicates that enterobiasis may be highly prevalent in that group.

Discussion

This survey shows that intestinal parasitism is fairly prevalent in immigrant children coming from endemic areas. Physicians treating children coming from endemic areas. Physicians treating children should be alert to the multitude of clinical manifestations, ranging from irritability to pneumonitis, that may occur in infected individuals. While intestinal parasitism may be ac-

cepted as a 'way of life' in the endemic settings from which the immigrants come, these infestations are not acceptable by the health standards established in this State. We recommend therefore that some means for routine examination and treatment of these new entrants be devised.

Physicians should also be mindful of the relatively high prevalence of *Giardia lamblia* observed in this survey. Giardiasis may present as an acute steatorrheic diarrhea or may be of a low grade chronic and episodic form from which the only complaint may be of 'feeling unwell' or abdominal discomfort. Parasitological diagnosis from a single stool specimen is often not accomplished in cases of giardiasis. Physicians should persist in laboratory examinations in cases where the infection is suspected. In many vague cases of gastrointestinal complaints, it should be suspected.

The need for further epidemiological investigations is indicated from the results of this survey. Toddlers, the 'sentinel' group most close to the soil and most likely to be infected, should be examined, to help determine the true state of

continuing transmission in various communities of Oahu. Surveys for intestinal parasites should also be extended to the other islands of the State.

Summary

Stool samples of 390 school children from five localities in Oahu were examined for the presence of intestinal parasites. Immigrant children, particularly recent entrants, showed a high prevalence rate of the 'ubiquitous triad': *Ascaris lumbricoides*, *Trichuris trichiura* and hookworm. Autochthonous transmission of these parasites does not seem to be occurring to any great extent, although hookworm was found in two locally-born children, and *Trichuris* in one. Physicians should also be aware of the relatively high prevalence rate of *Giardia lamblia* in both foreign and locally born children.

Acknowledgements

The skillful technical assistance of Mr. Mitsuto Sugi and Mr. Kenton Kramer is gratefully acknowledged.

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1. Alicata JE: Parasitic Infections of Man and Animals in Hawaii. Hawaii Agricultural Experiment Station Technical Bulletin no. 61 (1964).
2. Ching HL: Internal parasites of man in Hawaii with special reference to Heterophyid flukes. *Hawaii Med J* 20:442, 1961.
3. U.S. Immigration and Naturalization Service, Annual Report for 1973.

President's Message

Honored guests, fellow physicians of the Hawaii Medical Association. Today you have bestowed upon me one of the greatest honors that you can give to a colleague of your Medical Association. It is a privilege that I will always cherish and, hopefully, will be worthy of the trust and confidence you have given me in the next coming year.

I would like to now briefly express some of my thoughts to you. My first thought is that of gratitude. Truly, thank you, one and all, for allowing this Yobo, born on Maui, raised in the pineapple fields of Wahiawa, to be your President. Thank you for once again, indirectly, honoring my Mother who supported me through all my years of education and thank you for honoring my wife, Masa, and my children, who are here today with me.

In return for your trust and confidence I will strive to achieve the goals of the Hawaii Medical Association to the best of my ability. I am proud to be a member of the medical profession and sincerely feel that organizations such as the American Medical Association and the Hawaii Medical Association can sincerely promote the betterment of our profession through a democratic process. In this next year, my first duty will still be to my patients, but I assure you, that my very close second duty will be that of conducting the affairs of our great medical society which has been in existence for 100 years.

Very briefly I would like to emphasize three goals that I have set for myself in the next year. The first is that of internal communication. Communication within the profession, talking to physicians relative to the activities of the HMA and AMA. Overcoming a communication gap between the leaders and members of any organization is a major problem. If we can make some headway in narrowing this communication gap, I will feel that part of my goal has been achieved. The second is that of external communication. That is, communication with other organizations within our community. We need to improve our image, even more than the present respect we now enjoy. We need to be accused when we are rightfully wrong, but we also need to be commended for what we rightfully do in this community, which for many years, has gone unrecognized. I will not tolerate any slanted remarks on our Medical Society. Too many of these remarks are made on the basis of emotion, jealousy, and prejudice. So what's new? What's new is that, perhaps, we have been too inbred, perhaps we need to confront and communicate with others. Perhaps this may resolve some of the misunderstanding. Perhaps we will be accepted for what we are. To this effort we will try to communicate with other organizations, and in a sense, with the community in which we live, which we believe in, and in which we love.

And lastly, I would like the leaders of our Society to seriously consider a re-assessment of the goals of our organization. In many respects, it may be a re-affirmation of previous policy. In many other instances, it may mean a positive policy change because of external influences. We, as a profession, need to be credible and although I sincerely believe many of the efforts of our Association are far ahead of other professions in self assessment, I feel we can still do better.

And so, I sincerely feel that part of the activities of the next year should involve this process of re-assessment, to be followed with more fervent commitment to goals that we sincerely believe will benefit our profession, our patients, and yes, our community.

To some of you, my utterances in these last minutes, may be pure rhetoric. I assure you I have given it a lot of thought, and I understand the trust and confidence you have given me. I will do my best to deliver what I have proposed.

WINFRED Y. LEE, M.D.

Editorials

Communications and Goals: New Directions

As mandated by the House of Delegates, at the recent annual assembly of the Hawaii Medical Association, the HAWAII MEDICAL JOURNAL is adopting a new format, aimed at greater communication within the medical and paramedical community.

Thus, the JOURNAL is inviting hospital chiefs of staff each to assign a physician to submit news items for publication on a monthly basis. These items may be of medical, administrative or even personal nature, so long as they are of general interest to the HMA membership.

Similarly, each specialty society is being asked for such news input.

As in the past, the HAWAII MEDICAL JOURNAL will continue to accept scientific articles. More than ever, the future aim is that such articles shall have as wide an appeal as possible to the HMA membership, specialists and generalists alike.

News from the several County societies is also being encouraged, as well as Letters to the Editor.

Another feature which is projected will be Clinical-Pathological Conferences from the various hospitals in the State. Hospital staff members in charge of CPCs are invited to submit appropriate transcripts for publication.

The Editors,
HAWAII MEDICAL JOURNAL



Counties Elect—

HAWAII COUNTY—

President—Ruben Casile
Vice Pres.—Paul Caldwell
Secretary—Robert Irvine
Treasurer—Richard Lundborg

HONOLULU COUNTY—

President—Albert Chun-Hoon
Pres. Elect—Douglas Bell II
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Secretary—
Treasurer—Thatcher Magoun

MAUI COUNTY—

President—Marion Hanlon
Vice Pres.—William C. James
Secretary—
Treasurer—
William Grier Kepler

* * * *

HMA President Winfred Lee held a seminar for commissioners and committee chairmen on January 7. Briefing was given in goals and objectives and in committee functions.

First meeting of new Council held on January 10 (too late to be reported here).

* * * *

Workmen's Comp schedule out with five digit code relating to the current RVS. Computations of fees are still based on the 1965 RVS but are very much improved. The 25% differential for certification is eliminated. This is very real progress.

* * * *

Hearings are in progress relative to certificate

of need legislation and to DSSH rules and regs. With the wholesale changeover in administrative positions in state government departments not much new legislation is anticipated.

* * * *

Problems have developed in the TDI program since the inclusion of pregnancy as a compensable disability. The cost of this one item was about thirty percent of the total and brought the HMA rate from 45¢ to 58¢ per \$100 of payroll.

* * * *

Federal Legislation—most threatening and far reaching is the health care planning bill combining RMP, CHP and Hill-Burton. There will be a single agency rigidly structured with State and Regional Systems and area agencies with governing bodies made up predominantly of consumers. Operating rules and regs have not been released.

National Health Insurance is still an unknown quantity but some sources feel that there is not much chance of a bill this congress. We wait and watch.

* * * *

Professional Liability insurance is being reviewed in congress as it is becoming an acute crisis nationally. At this point it is not possible to predict what the future may hold because although Hawaii is a bright spot on the map, we are small potatoes in the whole picture. Losses of reserves because of the economic recession, increasing number of claims, increasing level of awards, and changing court decisions on technical grounds have all contributed to a very confusing scene. Some evidence points to a dramatic increase in professional liability suits in those states with no-fault auto insurance.

* * * *

Project Probables include funded projects on diabetes, arthritis, and hypertension.

* * * *

EMS progress continues. Four mobile intensive care training vans have been received. One will be leased by HMA to the City and County of Honolulu, the other three will go to the neighbor islands under lease to the Department of Health. Training proceeds apace with the fifth MICT class now finished—seventeenth EMT-A class has completed training and firemen, policemen, and lifeguards are now in the process. Seminars for physicians in emergency pro-

cedures are planned for January with category I credit allowed.

* * * *

HMA Staff Changes—Mrs. Bess Chang has been designated "Assistant for Special Events" and Mrs. Becky Kendro "Legislative Assistant" with additional responsibilities assigned to each of them.

* * * *

Meetings On The Calendar—Clinical gastroenterology and endoscopy post-grad course—February 9-16 at Acapulco, Mexico—registration fee required—for information write to Vernon M. Smith, M.D. 301 St. Paul Place, Baltimore, Maryland 21202.

* * * *

Rural Health Care Delivery Systems—G.N. Wilcox Memorial Hospital, Kauai sponsored by Schools of Public Health of Hawaii and California, funded by U.S. Public Health Service. January 16, 17, 18, 1975.

For a full listing of meetings consult the calendar in the JAMA.

* * * *

AMA House of Delegates actions were well reported in the December 9, 1974 issue of AM News—most controversial decisions had to do with increase of dues, deletion of advertising, and elimination of various committees and councils. Action taken by House of Delegates called for delay until a special committee of the House can report back to the house in June. A \$60 special assessment was voted in order to relieve the acute cash position of the AMA brought about by deteriorating reserves invested in equity holdings. (Sound familiar?)

* * * *

Out Of The Past—John H. Manwaring, M.D., 711 D, San Rafael, Cal. 94901, would like to know where his films are. He turned over some 16mm color film of Okinawa to an Okinawan Organization in Hawaii in 1946 or 1947. The filming was done right after the war and he would like to have any information he can get relative to the present location of the films. **WANT A JOB?** The army is looking for medical officers in examining and entrance stations—write Headquarters, United States Army Recruiting Command, Fort Sheridan, Illinois. 60037.

University of Hawaii seeks part-time physicians to teach the interdisciplinary aspects of delivery of health care services. Contact Family Practice and Community Health, U of H Medical School.

* * * *

Department of Labor is looking for a medical director, workmen's comp division. Interested doctors should contact Mr. Watanabe of the department.

* * * *

Family practitioner needed for Waipahu—call Mrs. Wakatsuki 677-0711.

* * * *

HMA Newsletter will be included in the Journal hereafter. Information of timely interest is solicited.

* * * *

Pediatric Behavior Management Conference, February 21-22, 1975. Sponsored by the Department of Pediatrics of the University of Miami School of Medicine.

For additional information contact the Division of Continuing Medical Education, University of Miami School of Medicine, Box 520875 Biscayne Annex, Miami, Florida 33152.

* * * *

Doctors Wanted . . . Trust Territory of the Pacific Islands needs board certified family practitioners, general surgeons, and internists . . . The practice would involve the management of tropical disease and teaching in a most pleasant island setting. Housing, transportation, and educational benefits provided. 2 year contracts. Write for details to: Robert Fisher, M.D., Dept of Health Services, TT of the Pacific Islands, Saipan, Marianas Island 96950.

* * * *

MEETING NOTICES . . . The Hawaii Society of Pathologists will hold their monthly meeting on Friday, Jan 24 at Straub Clinic. Cocktails at 6:30pm. (Jim Navin)

* * * *

NOTICE: Announcements must be in by the first week of the month. Write c/o Henry Yokoyama, M.D., News Editor, HAWAII MEDICAL JOURNAL; Mabel Smythe Bldg.

New Members



Ray T. Huffman, M.D.

347 North Kuakini Street
Honolulu, Hawaii 96817
INTERNAL MEDICINE



Eugene Lance, M.D.

1441 Kapiolani Blvd.
Honolulu, Hawaii 96814
ORTHOPEDIC SURGERY



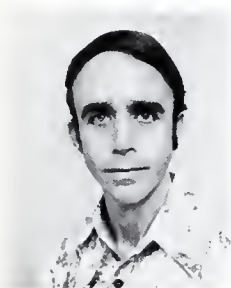
Herbert Aldendorff, M.D.

Hawaii State Hospital
45-710 Keaahala Street
Kaneohe, Hawaii 96734
PSYCHIATRY



Erlinda T. Magsalin-Cachola, M.D.

905 Umi Street
Honolulu, Hawaii 96819
INTERNAL MEDICINE



Forrest C. Brown, M.D.

888 South King Street
Honolulu, Hawaii 96813
DERMATOLOGY



Ronald G. Perry, M.D.

2221 South Beretania Street
Honolulu, Hawaii 96814
INTERNAL MEDICINE



William H. Burnett, M.D.

Maui Medical Group
2180 Main Street
Wailuku, Maui 96793
INTERNAL MEDICINE



Francis D. Pien, M.D.

888 South King Street
Honolulu, Hawaii 96813
INTERNAL MEDICINE,
MEDICAL MICROBIOLOGY



Joseph R. Cunningham, M.D.

Kona Medical Associates
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Kealahou, Hawaii 96750
GENERAL SURGERY



Marco Rizzo, M.D.

617 Piikoi Street
Honolulu, Hawaii 96814
PLASTIC SURGERY

Book Reviews



Supportive Care of the Surgical Patient

By William M. Stahl, 270 pp., \$13.50, Grune and Stratton, 1972.

This excellent short book on adjuvant care in surgery might be particularly appropriate for the older surgeon who is faced with self-assessment or recertification, or as an introductory text for the medical student, who could supplement the material with reading in a more comprehensive text. The chapters are succinct and to the point, and the bibliography remarkably comprehensive (67 references for the chapter on the respiratory system alone). There is good coverage of the major areas such as circulation, renal, lung, liver, etc., and also other systems such as the endocrines and emotions. Although perhaps not quite as complete as the American College of Surgeons text on *Pre- and Post-operative Care*, Stahl's book has a continuity, flow and style that makes it very readable; quite a tribute to the effort of a single author.

C.S. JUDD JR. M.D.

Lithium in Medicine

By Joseph Mendels, M.D., and Steven K. Secunda, M.D., 221 pp., \$12.50, Gordon and Breach Science Publishers, Inc., 1972

This volume is the most comprehensive book I have yet read on the use of Lithium in medical practice. The editors start out with an excellent review of the history of the discovery of the effects of Lithium in medicine and its eventual usage almost exclusively in the treatment of psychiatric disorders.

Each section of the book is preceded by an outline form of review of a topic such as the clinical aspects of mania or depression. This is then followed by the inclusion of several reprints from the literature of papers by various investigators written about the topic or closely related issues.

I found about three-fourths of the book to be fascinating reading. What interested me most was the clinical discussions of treatment and prophylaxis of mania and depression. The remainder of the book was tough sledding because of the intricate and involved studies discussed, such as the determination of Lithium in serum by atomic absorption spectroscopy and flame emission spectroscopy. One would have to be a physicist or biochemist to be able to appreciate the content of this part of the book.

In general I found the book to be a very useful and informative volume which should be read by every psychiatrist who uses Lithium Carbonate in the treatment of his patients.

EDWARD F. FURUKAWA, M.D., F.A.P.A.

Drugs of Choice

By Walter Modell, M.D., 832 pp., \$23.75, C.V. Mosby Company, 1974

This is not so much a how-to book as it is a what and why book. In other words, it is not a therapeutic "cookbook". It is a readable guide to the rational selection of the best drug for particular therapeutic problem. Many chapters list a mini-compendium of drugs, confessing to the fact that there is indeed no drug of choice for many situations. Fortunately for the reader, the authority usually tells us which one of the many drugs he would choose. The Drug Index section which in my opinion serves no useful purpose is the only bad thing about this otherwise useful book. I recommend it to all primary care physicians.

VINCENT S. AOKI, M.D., F.A.C.P.



Family Physicians

... it's the cap of the toothpaste tube!

Most confrontations start small—but they surely can grow into whoppers.

Dr. Manfred Marcus of California spoke recently to the Honolulu County Medical Society (while the election ballots were being counted) on the growing Union of American Physicians. One of the high points of his talk was in answer to a question from the audience as to whether it was "right" for doctors to go on strike at all.

Dr. Marcus' answer was a classic: "We don't need to strike. At least not in terms of refusing medical care. All we need to do is to refuse to take pen out of pocket. We can threaten to withhold signing our names to birth certificates, death certificates, sick leave applications, insurance forms, Medicare and Medicaid forms, etc."

You could see the brains of the sparse audience light up with thoughts and ideas engendered by this statement. Why, of course! But we physicians have to be united in the effort. One doctor could spoil it all by signing his name in place of all the others.

So, let's start small. Here is the way to do it!

Starting with the feds, but percolating down through the state agencies, there are DHEW rules and regs that require the nurses in nursing homes (call these institutions by whatever euphemism you wish) to recap* every patient's orders once a month. This the nurses are willing (?) to do, to make it easier for us doctors, and because the feds and their underlings know that most physicians would either do it illegibly, or delay, or forget forever. All that remains for us to do, then, is to sign the recap once, twice, or twelve times a year. A small matter. Oh, yeah? But a big principle!

*from recapitulate: ie, rewrite.—Ed.

Recapping orders is:

- 1) Extra work for the nurses, who have enough governmental, do-gooder busy-work to do;
- 2) **Increasing the chance of human error** which, times 12, leaves infinite chances of compounding the error;
- 3) Insulting the physician, by implying that he doesn't know what he is doing to his patient;
- 4) Insulting the nurse as not competent enough to know what the orders mean or when to consult the physician about a reaction to a drug.

We have enough to do caring for the sick without doing busy-work besides.

Would you, as physicians, sign a recap list of medications without checking and comparing the new and the old? If you don't compare, you're a damn fool. If you do this extra work for the government without additional recompense, you are again a damn fool!

When I sign orders on nursing home patients, I specify: "Do **not** recap these orders, ever!"

Any of you lily-livered denizens of a nation of sheep care to join me?

Remember! It's someone forgetting to put the cap back on the toothpaste tube that can lead to a divorce!

J.I. FREDERICK REPPUN, M.D.

Queen's Medical Center
St. Francis Hospital
Straub Clinic & Hospital
Wahiawa General Hospital

In determining whether or not hospitals or health-related institutions could qualify for accreditation of their CME programs, the following standards should be considered:

Organizational Commitment

The following areas are deemed as critically important aspects of an organization's commitment to improving patient care through continuing medical education:

1. Explicit support of continuing medical education by the organization and its members.
2. Provision of a budget and facilities for continuing medical education of the membership as evidence of such support.
3. A continuing medical education committee with membership participation in education planning.
4. Medical education programs, including availability and use of expert knowledge of educational methods, wherever practicable.
5. Coordination and cooperation with other education programs in the area in sharing resources, and evidence of efforts to meet the educational need of physicians in the community, and to avoid duplication of programming.

Program Developmental Goals

1. Need Assessment, as developed through feedback from previous programs, self-assessment testing, performance analysis, or other objective mechanisms.
2. Clearly defined objectives for each educational activity based on these need-assessment procedures.
3. Planned learning experiences, designed to bring about these specific objectives, selecting the most effective educational method for the particular need, whether knowledge, skills, attitudes or performance are to be changed.
4. Evaluation of each individual educational activity in terms of the established objectives, and of the entire continuing education program of the organization, through review procedures similar to those followed in assessing need.

Other activities of the HMA Continuing Medical Education Committee have been the survey of Kapiolani Community College's Medical Assistants Program, and a survey of a nationally-based, locally-given program by the Joint Implant Surgery and Research Foundation program per requests from the AMA Council on Medical Education. Drs. Felix Lafferty, Sherrel Hammar, and Ivar Larsen generously volunteered their time to carry out these last two surveys requested of us by AMA.

Surveyors of the Children's Hospital and Hawaii Thoracic Society were Drs. Elisabeth Anderson, Harry Arnold, Jr., Ralph Berry, Hing Hua Chun, Sherrel Hammar, Edgar Ho, Roy Kamada and James Orbison, with the assistance of Drs. Rutledge Howard and Richard Opfell.

The HMA is grateful to them for their time and the expertise they have gained in this important area, aimed to serve their colleagues in meaningful ways.

CONTINUING MEDICAL EDUCATION

Announcing local Category 1—
Credit CME Courses*

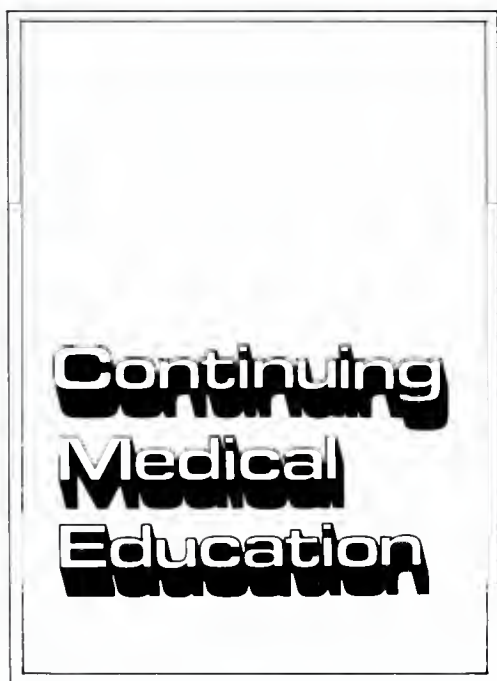
Kauaikeolani Children's Hospital:

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program
4. April 2, 3, & 4 Post-graduate Pediatric symposium

Emergency Medical Seminars for Physicians:

1. January 26 & 27, 1975 (lecture) Ilikai
2. January 28 & 29, 1975 (clinical) St. Francis Hospital

ELISABETH K. ANDERSON, M.D.



In November, 1974, the Continuing Medical Education Committee of HMA, H.H. Chun, M.D., Chairman, granted accreditation for Category I programs of Kauaikeolani Children's Hospital and the Hawaii Thoracic Society. This is equivalent to accreditation by the AMA. Programs of Category I nature will be published in the JOURNAL.

Accredited Programs: (Only time spent in actual sessions is applicable)

Kauaikeolani Children's Hospital:

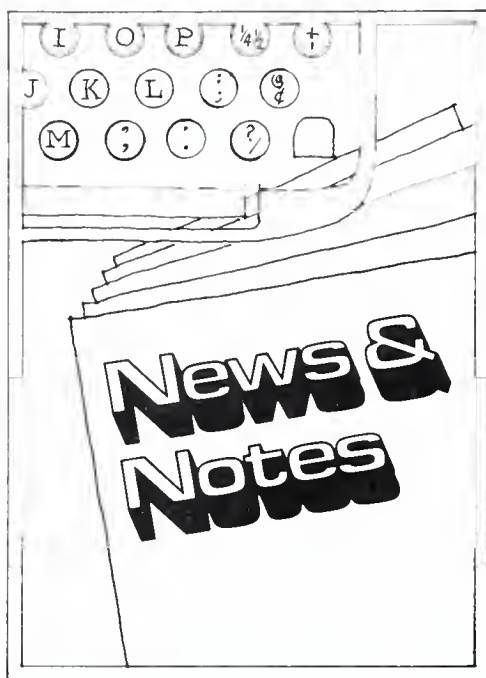
- a) Monday noon seminars,
- b) Weekly pediatric grand rounds,
- c) Visiting professors' program.

Hawaii Thoracic Society's Fireside Chat and designated scientific programs at time of HMA annual meeting (October 29-November 1, 1974)

Hawaii Medical Association Scientific Meetings

Survey for accreditation of their CME programs has been requested by:

Hawaii Chapter, American Cancer Society
Hilo Hospital
Kaiser Foundation Hospitals
Kapiolani Maternity Hospital
Maui Memorial Hospital



Life in These Parts

Mice were plaguing the residents of Kihei, Maui, where "swarms of the furry creatures were underfeet everywhere." Along came **Alice Broadhurst**, Maui District health officer and mouse killer extraordinaire, who first reported, "We have been killing them by the thousands, but they are there in the millions and we can't keep up with them." But despair, she did not... She had a ton of poisoned oats dumped by a crop dusting plane over a 10-mile-long 600-foot strip and 3 days later, proudly announced, "thousands of mice bodies now litter the region." Alice, the mouse killer had won her private war with the mouse invasion...

During a medical symposium at Spokane's Expo '74, **Walter Sirode**, who devotes part of his time to Hawaii Health Net, described health as a dynamic relationship between the individual and his total environment... "Many patients who come to me and other physicians don't want to be responsible for their own treatment... They just don't want the responsibility of their own health... Too many people believe health is something you can buy from a doctor in a hospital." Walter hopes to do an interface study to put the medical profession in contact with an individual's alternative approaches to good health, eg, acupuncture, meditation, Yoga, bioenergetics, and folk medicine...

Milton Howell of Hana had an agreement with Charles Lindbergh during his final week... Milton says, "He asked me to assist him to make his last, final act—his death—a constructive act... He did not avoid his own death, but accepted it and planned for it... He died simply, as he lived... He died privately, as he lived or tried to live, and he died comfortably... at home." Milton would like to be able to write the following prescription in cases where it is warranted: "He may eat what he pleases, he may sleep as he pleases, he should have medication for comfort according to his need, and he should receive large doses of consideration and kindness..."

Milton achieved further fame in the September 16th issue of the JAMA wherein he was featured in an article, "Hawaii: Idyllic Setting for Modern Medicine."

St. Francis Hospital has a physician acupuncture program for the drug detoxification unit. The detoxification begins on an inpatient basis and then after the withdrawal stage, the patient is continued on an outpatient basis. But the St. Francis unit has a competitor—an enterprising Chinese importer of wigs who has started "Acupuncture Services, Inc" in the Ala Moana Building and has advertised for volunteers for free acupuncture treatment to cure drug addiction...

Gleaned from Tom Horton's column entitled "Surfolderol": "Silver-haired Bef Alley absolutely shocked **Dr. John Balfour** after her mastectomy by telling him, 'Why didn't you graft it on my back so I'd be more interesting to dance with?'"

Columnists are funny people... Tom Horton finds amusing the Lomotil ad in the JOURNAL which says, "Physicians prescribe Lomotil more often than any other drug when the urgency for the control of diarrhea is most distressing." Tom says, "But there's always a bottom line, in small type, and the one for Lomotil says, 'Warning: May be habit forming'" and adds, "But then so is living in Hawaii and traveling the world."

The Hawaii Dental Service awarded a \$6,000 grant to fund a year-long project by 100 Oahu dentists to screen their patients for previously undetected high blood pressure... Knowing how our own BP must jump whenever we sit on a dental chair, we wonder if our dental colleagues may not end up with a lot of normal abnormalities? We shall meanwhile gird ourselves for a deluge of unnecessary BP referrals...

The Attorney General ruled that the State no longer can require U.S. citizenship as a qualification for the practice of medicine in Hawaii, but it should not open the floodgates, because as **Mor J. McCarthy**, chairman of the State's Board of Medical Examiners points out, there are other procedures insuring competence including 3 years of training in an approved hospital residency program, passing a 3-day FLEX (Federal Licensing Exam) and foreign graduates must pass a medical English comprehension examination.

A Honolulu physician observed that since the No Fault Auto Insurance Law became effective last September 1, patients who were in rear-end collisions seem to have a less tendency to hang onto their symptoms...

"Mr. Nude Hawaii," **John Corboy** of Kaiser, was to defend his title in November, but we have not as yet learned if he was successful (Frankly, most of us are envious, rather than critical...)

One day, **George Suzuki** got a garbled message from Mrs. Toledo, our friendly Home Care nurse, which sounded like: "The patient has a hole in his cock..." Realizing the connection was bad, George asked her to call back and she replied, "I'll call back from my orifice." (She did call back, from her office, and it turned out that the patient had developed a sacral decubitus so deep that the coccyx was showing...)

Queen's Chief of Staff **Ben Tom** listened fascinatedly to the case presentation by the intern. "An 80-year-old Chinese man was seen at the ER presenting the 'O' sign... Despite all heroic efforts, he soon presented the 'Q' sign..." Ben interrupted and asked the intern to elucidate on the 'O' and 'Q' signs... The intern forthwith formed an 'O' with his mouth to demonstrate Kussmaul breathing and then let his tongue hang out of the lateral corner of his open mouth to indicate demise or the 'Q' sign...

Miscellany

Captain Putnam and his union troopers marched into a southern town and needed billets for the night... He knocked at the first home and the lady with typical southern hospitality offered to put up one trooper for the night... The captain ordered, "Corporal Peters, fall out! You can stay here tonight." The captain then approached a rather large mansion which had seen better days... A knock and a heavily painted buxom matron appeared with a bevy of southern belles in various stages of dress peeking from behind her... "Can you take care of some of my men for the night?" he asked politely... The matron was delighted, "Sure! How many men you got? We'll take them all." The captain replied, "I have fifty men without Peters..." The matron's eyes widened and she exclaimed disbelief, "You gotta be kidding..." (As told by **Ben Tom** who heard it from our tennis playing architect, **Dick Dennis**...)

Locker Room Jokes

Anabelle and Polly Ann were neighbors and the best of friends who spend endless hours gossiping over their backyard fences... But one day, Polly Ann discerned that Anabelle was angry... "What's bothering you Anabelle? I'm your best friend and you can tell me your problem..." "Well, Polly Ann, I hear you told someone that my Jeb has a wart on his penis." Polly Ann was quite adamant, "I said no such thing! Honest, I only said it felt like he had a wart on his penis..." (Another **Dick Dennis** joke modified...)

HMA Prexy Tom Frissell's Witticism (Gleaned at the HMA House of Delegates meeting)

"...and another ground rule... If we have not concluded by 6 p.m., we will recess till 7 a.m. tomorrow..." (veiled threat)

"You have heard the motion... Discussion... All those in favor of the recommendations, say Aye! Opposed..."

(After a ticklish resolution) "Is there any discussion? (Silence) Well I'll be damned!"

(When the Ayes and Nays sounded equally loud) "Okay! We're going to split the hand..."

(Again after a close vote) "All those in favor, say Aye! ... All those opposed, Nay!" "All right, we'll do this with hands!"

(Following a prolonged discussion on an issue) "How about the rest? You've heard the recommendation... Let's keep it clean..."

"So he recommends the report be filed... In the liquor locker?"

Chairman **Doug Bell** reading the President's Report (page 39) needled, "The committee next considered the President's Report and after sober thought and reflection recommends approval of the report."

When our dissenter **Fred Reppun** complained, "By the way, with three reference committees operating simultaneously, it's difficult for a member to express his views..." Tom quipped, "It's better than four."

(In the wake of a rather nebulous statement by a delegate) "Can you rephrase that to get us out of the woods? I'm sober..."

Re the Woman's Auxiliary Report 5½ pages double spaced: "Maybe we should send Annie (Ann Catts known for her brevity and preciseness) over to help them make a report..."

The Acupuncture resolution prompted a polite debate between **Neal Winn** and **Grover Batten** vs. **Al Chun Hoon**... Al Chun Hoon: "I don't want to get into the merits and demerits of acupuncture..." Tom: "Well, did we kick it around enough?" Apparently not, because the debate continued... Someone noted that the resolution was submitted by **Ed Boone**, surgical director of HMSA. **Harry Arnold Jr.** recommended, "Delete Acupuncture from the surgery section of RVS and include it under the physical medicine section."

During the furor, Tom was firm: "I think I have the prerogative to..." "It may Goddamn well be approved..." Then turning to Harry Arnold, Tom pleaded, "Harry, you are the parliamentarian... Get me out of this..." Still later, "So you now have heard three parliamentarians tell me that I goofed..."

Claude Caver's Humor...

We sat next to our red haired humorist at the Peer Review Committee meeting and between cases, he scribbled on a paper napkin: "5Q + 5Q = 10Q". Claude whispered, "Did

you hear that the director of "'The Exorcist' is coming out with something more painful to sit through? It's called 'The Circumcist'..." When **Rowlin Lichter** concluded his presentation, with the remark, "I think the patient is devious..." Claude commented candidly, "You mean downright crooked..."

Later, he sketched painstakingly the following on the same paper napkin while he challenged us to decipher:



When we admitted it was beyond our comprehension, he explained that it has to be read from right to left and that it read: "Holy Smoke, Zulu! Look at the ass on that Kumu..."

After the meeting, we were treated to yet another joke: (A take off on **Tom Payne's** "These are the times that try men's souls...") "A high school coach with losing track teams year after year, evolved a new training system whereby his teams began winning meet after meet... Curious, the other track coaches begged him to divulge the secret. He showed them the special track shoes he had ordered from Hong Kong with built-in stop watches and stated, "These are the soles that try men's times..."

Sportsmen

In a field of 42 participants, **Mike Okihiro** shot a net 65 to win the Kaneohe Community Club's annual summer tournament July 21 at Kahuku Municipal... One September weekend off **Tom Frissell's** Haleiwa home, **Diane Fujikami** speared 3 Aholehole to Ray's one. And Tom claims he got a 3 lb. Moana while a 5 lb. Kumu shook off his spear...

Memo to **Charley Ching** and **Ben Tom**, our newly crowned HMA doubles champs for 1974: "The Overhead" (from *So You're Going to Take Tennis Seriously?* by Jack Roberts... How to deal with guilt, blisters and over achievers.) "The overhead smash (as in in-flight booze) involves downing a high ball... Assuming you are of age, and faced with this opportunity, the idea is to (1) hit the ball, (2) to a place, (3) where your opponent can't return it... These targets include the baseline, the court corners and the *opponent's stomach*. It's great fun and a smoke rich in aggression release."

Ed Izawa of the Square to Square swing, hit a perfect No. 3 wood on the 14th Hole at Mid Pac on the 15th of November, a Thursday, and holed it in for his 2nd Hole-In-One. His first was on the 9th Hole at Makaha West several years back and he took a trip to Europe with the Hole In One Club benefits... He now joins the ranks of the physician golling greats with 2 hole-in-one's, the only other we know of being **Dick Lam**....

Of Football and Anxious Parents...

We have never been much for spectator sports but now with a son playing varsity offensive tackle, we have joined a group at the Ewa goal bleachers which include **Fred Reppun** and family whose son plays center and **Jim Marnie** whose son plays backfield and is Punahou's star place kicker... We also see the Baileys at every game whose son now coaches and formerly played on the varsity... We frankly attend these games just to pray that our son and for that matter all sons avoid serious injury... **Ben Tom**, team physician for St. Louis had a son playing for Pac 5 last year and is now a relieved father since the son did not turn out this year. He still recalls so vividly when St. Louis player Medeiros suffered his permanent neck injury last year and he quotes statistics that 1 out of 10 suffer permanent knee injuries... At one game it was announced, "Mr. and Mrs. _____, please report to Kuakini emergency... Your son has been injured..." and our nerves became even more frayed....

Miscellany

A teenager took issue with the saying, "Women, like wine, improve with age." He commented disgruntledly, "It's more likely they pop their cork, lose their fizz and settle to the bottom as sediment." (Told by **Betty Liljestrand** at the AMA meeting and heard by **Betty Anderson**).

The Archbishop called the Pope to tell him of a marvelous revelation which was both good and bad. He explained, "Jesus Christ just called me to wish me a joyous Christmas . . . The only trouble is, the call came from Salt Lake City . . ." (Contributed by **Betty Anderson**).

Daisy, Daisy,
Give me your answer, do!
I'm half crazy
Over Pope Paul's point of view.
It may lead to world starvation,
But constant procreation
Is what we're for,
It says in your
Encyclical made for two!
(Gleaned by **Harry Arnold Jr.** from *Punch*)

Professional Moves

1974 was the Year of the Tiger . . . And a fierce year it was for the medical community . . . In October, orthopod **Richard West** joined the Maui Medical Group straight out of residency at University of Pittsburgh. (Dick chose to practice in Hawaii because of the natural beauty, water sports, sunshine and the lack of cold winters. We learned that Dick's hobbies are photography, bicycling, scuba diving, sailing, and water sports . . . No wonder . . .) **Sowers & Strother, MD, Inc.** announced the opening of a Kihei Branch Medical Office. In Honolulu, pathologist **Alfred Scottolini** joined the Kaiser Group, psychiatrist **Francais Saculla** opened the Saculla Clinic at the Gold Bond Bldg. (specializing in psychiatry, psychosomatic medicine, hypnosis, weight control, smoking habit elimination, and complete testing and counseling services) Dermatologist **Joseph Hathaway** (who after retiring from the State dabbled awhile in real estate and did real well too) joined the Honolulu Medical Group. Straub Clinic announced that **Francis Pien** will handle infectious diseases and clinical microbiology, while **Rodney Matsubara** will be in its Primary Care Dept.

In November, orthopod **Lloyd Tom** opened his practice in Hilo, and on Maui, internist **William Burnett, Jr.** joined the Maui Medical Group after 22 years in Seattle, Washington. (Bill had been vacationing every year for the past 10 years in Lahaina and his hobbies are fishing, skiing, tennis and golf.)

In December, **Perry Hudson**, former professor of urology at Columbia University, joined the Maui Medical Group. (Perry has published over 100 scientific papers and written chapters in several textbooks, and is a recognized world authority on prostatic cancer. (Perry is an avid tennis player, and sailor and enjoys the outdoors . . .) Back in dull Honolulu, Ob Gyn man **Gary Fujimoto** joined **Joseph A. Brock** at 1481 So. King, GP **Chuen Lau** joined the Kaiser Group, psychiatrist **H. Russell Pickering** opened at 1287 So. King Street, and GP **Pablo Chau Chan** opened at 95 South Kam Highway, Wahiawa.

Elected, Appointed, Honored

The Honolulu County Medical Society elected **Al Chun-Hoon** president, **Doug Bell II** president-elect, **Ann Catts**, secretary, and **Pat Walsh** treasurer. **Fred Reppun** was named Hawaii's Physician of the Year by his colleagues and the A.H. Robins award was presented to him at the 118th Annual HMA Meeting. Fred was described as "conscientious, de-

voted, tireless, concerned, vocal, loyal and a resourceful family practitioner, citizen, husband and father." (And we sincerely concur . . . Never have we seen an active practitioner so involved in so many activities) Our illustrious editor **Harry L. Arnold, Jr.** ("Az") has been named the first president-elect of the 4,000-member American Academy of Dermatology and will take office next December. Az is the first president-elect because the bylaws were just changed to newly create this office. **DeWitt Hendee Smith** of Hilo will serve on the 1974 Committee of Selection for the Rhodes Scholarships in Hawaii, which will designate two nominees to represent Hawaii . . . **Pauline Stitt**, U of H professor of maternal and child health, received the American Academy of Pediatrics' award "for outstanding community service to children through teaching, public service, and innovation in patterns of patient care."

James Penoff and **Philip McNamee** are among five men to become directors and active members of the Kapiolani Hospital Auxiliary . . . (Men's lib . . . eh?) In October, wheelchair-confined **F.J. Pinkerton**, still feisty as ever, was honored by the Blood Bank of Hawaii, which renamed its building the F.J. Pinkerton Building . . .

Gerry Flick of Kailua-Kona who has both law and medical degrees, was recently made a Fellow in the American College of Legal Medicine . . . **Yutaka Yoshida** was elected director of the Kuakini Hospital board of directors . . . **Melvin Levin** was appointed the UH Medical School's new Pilot Arthritis Center at Kuakini Hospital which will diagnose cases on referral from physicians and return the patients to referring physicians with recommended treatment regimens, thus making available the latest in treatment of arthritis . . . The Hawaii Chapter of the Arthritis Foundation elected **Arthur Wong** one of two vice presidents, and **Edward Kamin**, **Eugene Lance**, **Melvin Levin**, **Roger Ogata** and **Andrew Sackett** directors.

Travelers Abroad

Orthopod **Al Chun-Hoon** had checked into a Taipei hotel and, exhausted from the long trip, went to bed early. Around 2 am, he was awakened by knocking on the door and a male voice repeating "Message! Message!" Al yelled, "Slip it under the door!" Again, "Rap! Rap Message! Message!" Again Al yelled, "Slip it under the door!" Then came a feminine voice, "Not message! Massage!" (As heard by **Tom Thorson**)

Kam School president Dr. Bushong was vacationing in Italy. Having a phobia for hotel fires, he would customarily check for the nearest fire escape. So, when he checked into a 3rd story hotel room, he went looking for the fire escape . . . He spotted a door with a sign so he pushed the door open and discovered a man sitting on the john. "Pardon me, I was looking for the fire escape," he explained. No sooner had he closed the door and was walking down the corridor when there was sudden patter of footsteps behind. Here came the man from the john wild eyed and excited, pulling up his trousers and asking, "Where's the fire? Where's the fire?" (Also told by **Tom Thorson**).

Pac PSRO president **Wini Lee** was on a site visit in Ponape as per request of the TT physicians. Ponape has a rainfall of 300 inches, lush vegetation and a torrid humidity. As Wini emerged from his 5th consecutive cold shower of the day, the perspiration already running down in torrents on his brow, he asked beseechingly of **Jon Won**, PSRO project director, "Jonny! What the *heck* am I doing here?"

Miscellany

(Aggie and Hilly Billy jokes to replace our Polack jokes) Zeke with a happy grin showed Jeb what he had in his cupped hands . . . "This is my lucky day . . . Look what I almost stepped on . . ." (As told by our tennis-playing architect friend, Dick Dennis)

You know why there were no Aggie sailors on the Pueblo? Because it was an intelligence ship (**Claude Caver's** contribution)

You know who won the Aggie beauty contest? Nobody . . . (Another Claude Caver's contribution)

Have you heard? The Aggie Savings and Loan has a new slant . . . "Bring in your toaster and you get \$500.00" (Also told by Claude Caver)

Letters To The Editor

The assignment feature of the Medicare program has always been a paradox here in Hawaii. While the assignment acceptance rates in other areas have been as high as 80 to 90%, the rate for Hawaii in 1973 was 33.5% (The national average was 56.9%). I feel that the advantages of accepting assignments are as follows: 1. Speedier payment. Whereas 90% of Medicare claims are paid within 30 days, the assignment acceptance claims are paid in 12.14 days. 2. Ease of claim filing since the physician's office assists the patient. 3. Aetna can furnish claim forms with the physician identification printed. 4. The physician's collection fees and bad debt writeoffs can be reduced. 5. The physician's immediate revenues will be increased and the payment of larger portions of his bill will be ensured. 6. Billing, collection and personnel expenses will be minimized. 7. Statistics for the first quarter of fiscal 1974 show that less than 50% of the Medicare claims were reduced with an average reduction of \$5.50 per claim. Therefore, if the physician's billing, collection and other related expenses amount to more than \$5.50 per claim, the physician should seriously consider accepting assignments.

I respect the physician's right to choice of payment method, but I would encourage him to consider the advantages of accepting assignments.

Bob Grathwahl
Director, Aetna Medicare

Entrepreneurs

When orthoped **John Cooper** retired in 1969, he refused to stop living. He now takes four courses at Honolulu Community College and is concentrating on auto mechanics and his "Garden of Eatum" (a half acre property of Nuuanu Pali Drive with 250 plants and trees including lilikoi, lemon, guavas, avocados, mangoes, and bananas). John says, "Retirement is a continuation of life with some modification. I used to graft skin—now I graft trees. You apply what you've learned or you learn a new trade, but don't just sit around. Do something."

E. Gordon Dickie returned from an East African safari and discussions with **Richard Leakey** in Nairobi and **Jonas Salk** in La Jolla to gather material for a new book on animals, people, and politics.

In December, medical reporter **Pat Hunter** reported on a successful caesarian section by **Francis Terada** on a patient anesthetized with acupuncture **only semi-successfully** when one of the battery powered electrical stimulators failed and conventional anesthesia had to be given . . . Francis said he felt that when the technique is perfected and instruments standardized, acupuncture anesthesia could be particularly helpful for women with toxemia of pregnancy in whom general anesthesia poses real dangers . . .

Gems from the AMA Meeting

A farmer had a ram who became disinterested in the ewe at mating time . . . He called in a vet who examined the ram and then gave the farmer some medication. The ram's vitality and virility improved so much that he not only took care of his own flock, but jumped the adjoining fence and took

care of the neighbor's flock as well . . . The grateful neighbor amazed at the ram's antics asked the farmer: "What was it that the vet gave you? . . ." The farmer replied, "I don't know, but it certainly tasted like cinnamon . . . and gave me a belly ache . . ."

"Struggling with today's problems is somewhat akin to watching a fat lady putting on a girdle . . . ie it is a struggle to keep a bad situation from spreading . . ."

"The microphone is like a spittoon . . . You have to hit it straight on, or you shouldn't bother to use it . . ."

(Collected by Betty Anderson)

Health Department

Back in August, when Hawaii county reported only 8 cases of gonorrhea for the month of July, District Health Officer **Audrey Mertz** complained that doctors were not reporting all cases of gonorrhea they treated. She said, "Although doctors are not required to report the names of infected persons, they are supposed to tally the number of cases they treat."

Also in August, Maui County District Officer **Alice Broadhurst** announced that the Adult Polio Immunization program for Maui had been an overwhelming success with over 9,000 persons immunized . . .

In December, **Ira Hirschy**, our respected chief of the communicable disease division, announced that leprosy patients no longer need hospitalization. He reported that the patients and residents remaining in the state's two leprosy hospitals have been told that they are free to go at any time. Ira reported that the number of newly discovered cases remains relatively high, 28 for 1974 and 39 for 1973. These are primarily among immigrants from Samoa and the Philippines.

Sportsmen

Straub neurologist **Mike Okihiro** may give up the practice of medicine and become a touring golf pro. He recently won first prize and 200 in the Lady's PGA tournament in Kona . . . We last reported that golfer **Phil Lee** had lost 30 bottles of Royal Salute to **Joe Nishimoto** in a friendly wager . . . We now learned that Phil recently played with Bob Hope, Aku, and Jeff Harman at Waialae in September . . .

Kaiser physicians **Shig Horio**, **Wayne Limber** and **John Thompson** surf off the Ala Wai Yacht Harbor before morning rounds. Shig and Wayne have been doing this for 10 years and John the past 4 years. Before Shig purchased his waterproof watch, his nurse had to hang a red skirt on the balcony to signal him when it was time to come in. Shig also runs for half an hour before leaving home in the morning and again after getting home at night. Shig says, "It's all part of practicing what you preach."

When football was in danger of being dropped at the UH campus a dozen years ago, **Richard You** personally underwrote the 1962 and '63 seasons by spending over \$12,000 to keep it going . . .

Honolulu cardiologist **Alfred Morris** and Tripler orthoped **Bruce La Follette** belong to The La Mariana Sailing Club of Keehi Lagoon which "rose from a junkyard, grew like Topsy, and now looks something like a South Seas bar out of an old John Wayne movie . . . It clings to life on a sliver of land by Sand Island, downwind from the HC&D repair and gear shop, Kona wind from the sewage outfall, and directly in the path of the jets from Honolulu Airport" (Sounds beautiful and intriguing . . .)

Hors De Combat

When Andrew Chang, State director of Social Services, wrote Hilo psychiatrist **C. Stanard Smith** that he was suspended indefinitely effective Oct. 15 from the Medicaid pro-

continued page 38



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Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic strep-

tococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

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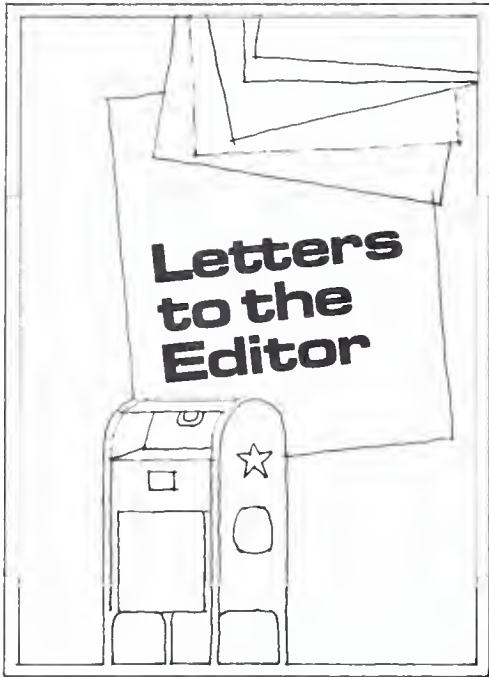
Usual adult dosage: 2 Gm (4 tabs or teasps.) initially, then 1 Gm b.i.d. or t.i.d. depending on severity of infection.

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To The Editor:
 The Health Screening for the Elderly Project, sponsored by Hawaii Senior Services, Inc. and recently funded through the Regional Medical Program of Hawaii, will be holding health screenings during the next few months in Waimanalo, Palolo, Haleiwa, and Kalihi-Palama. Participants in whom test results are outside normal limits, as set by our Medical Advisory Board, will be encouraged to see a physician of their choice.

Participants will be made aware that the screening does not replace private medical care. This program aims at educating toward earlier detection and treatment of chronic diseases of aging. This project has a volunteer Medical Advisory Board. For further information, contact Mrs. Reta Maag, Director, Health Screening Project, phone 523-1602.

RETA R. MAAG
 Project Director
 Health Screening for the Elderly

Our 'Angels'

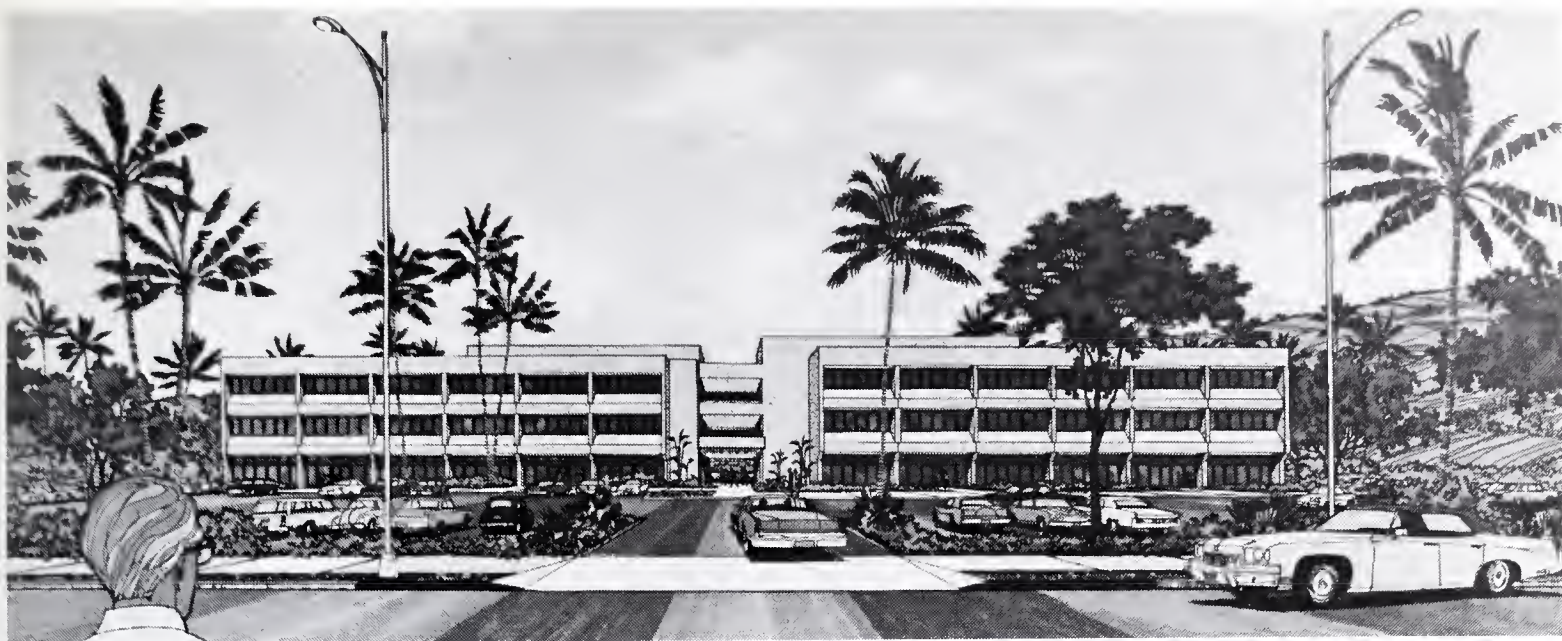
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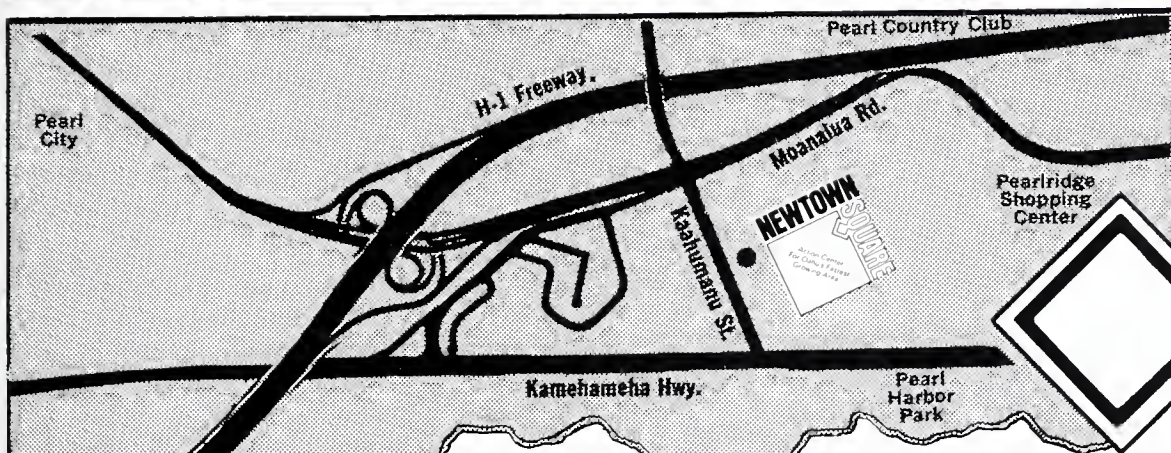


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gram, because he had "prescribed an unreasonably large quantities of controlled substances at close intervals," and that "these prescriptions were over and beyond recommended dosages for these substances", the psychiatrist took the matter to court...

Psychiatrist **Fred Weaver III** sued the State for \$1.32 million in damages because his contract was not renewed at a Kauai hospital. Fred blamed political maneuvering and the allegedly "arbitrary and capricious manner" of acting governor Ariyoshi and also charged that because he is black, he was denied public employment and his constitutional rights.

When Maui Memorial Hospital had to close 32 of its 145 beds and limit admissions "temporarily" due to a shortage in its nursing staff, **William Hoskinson** took a less charitable view of the State's nursing problem; "It's a chronic, terrific problem." He blamed the State government in Honolulu for a lack of concern about medical care on the neighbor islands... "They'd like everybody to go to Honolulu for their elective surgery because it would be cheaper that way for the State..."

Casper Rae, who practiced at Wilcox Hospital on Kauai from 1968 to 1973, sued the Hospital for \$1 million and sought full reinstatement of his OB privileges. The individuals named in the suit include **Peter Kim, William McLaughlin, Patrick Cockett, Clarence Funaki, Eugene Rames, Wallace Green, Patrick Aiu, Robert Hamblin, Gonzalo Geroso, and Robert Emrick**, and some non-physicians... He claims that the defendants acted to restrict and remove his OB privileges without right of due process in violation of his constitutional rights and that the defendants "made and published untrue and defamatory remarks about his professional training, skill, and knowledge."... Tsk! Tsk!

Nearly four years ago, **Jack Morris** of Lahaina assisted a Tatsuichi Oyama, a Honolulu electrician who fell off a barstool in a Lahaina bar. Oyama subsequently held Jack liable for spinal injuries he sustained and accused Jack of "gross negligence" and "wanton acts of omission" and asked \$2.5 million in damages. Oyama had been drinking heavily and Jack, who was in the bar at the time, examined him, then carried him to an apartment after he was unable to find any physical problems. A mistrial was declared after a month-long trial in 2nd Circuit Court in September... (Let's be wary henceforth of drunks who fall off bar stools... despite the Good Samaritan law)

"Tempest in pot tea cools off" A Frank Pagan grew marijuana for medicinal tea for his wife dying of lung cancer, which he used for pain killer and appetite stimulant. He was charged and later freed when the prosecutor dropped charges in the Hamakua District Court...

Oncology Dialogue

A 51-year-old man with early bronchogenic Ca was having

a vaccine prepared from tumor tissue removed at surgery. Immunotherapist **Ben Gordon** was being pumped for information:

Ben: "I wish to reiterate that immunotherapy is of little use in anyone but patients with very limited disease... It's like trying to shift a ton of coal with a teaspoon... We must use it only when no visible tumor is present..."

Chemotherapist **Quint Uy** asked, "What's been your experience thus far..."

Ben: "Anecdotal... People claim it's great, but I have seen only anecdotal data thus far..."

Moderator **Grant Stemmerman** concluded: "In summary, then, we are doing nothing for this patient except immunotherapy till he gets recurrence..."

A 61-year-old caucasian man with epigastric distress of 1½ months' duration and an 18-lb. weight loss in 3 weeks had a CEA of 20 and an infiltrating gastric Ca per UGI series... Stemmy quizzed, "Is he really caucasian? It's unusual to have gastric Ca in caucasians, except in Portuguese..." Oncology nurse **Pat Sato** set the record straight? "He is Portuguese..." Stemmy needed: "His likelihood of survival is ½ of 1%. With that, we'll ask Quint if he would start chemotherapy..." Quint was dogmatic: "Certainly! I think palliative chemotherapy is indicated. We can use a single agent or multiple agents," and admitted, "Our experience with single agents has been poor." Quint then proceeded to enumerate several known agents available, but did not mention Mitomycin in his armamentarium... Stemmy noted this omission and quizzed, "You will not use the Mitomycin group?" Quint was evasive: "Well, most of the favorable data on Mitomycin comes from Japan and our experience here has not been duplicated." Stemmy was insistent: "When I was in Italy (the recent International Cancer Symposium), many Japanese groups presented favorable data... I personally would hope if chemotherapy is used, that it would be used vigorously... and I hope Mitomycin C would be used..."

Incidental Intelligence

Grant Stemmerman sez: Recent studies show that 2.8% of the Japanese in Hawaii and Japan are carriers of Hepatitis B antigen and that only 14% of the Japanese population have immune bodies... Therefore hepatitis is a greater threat in hospitals here than Tbc...

Re adenoCa of the common bile duct: The incidence in Japanese in Hawaii is 4 times greater than for other racial groups.

Re Whipples: Total pancreatectomy is better than a partial pancreatectomy since preserving the pancreas results in secondary Zollinger Allison and atrophy of the exocrine glands...

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Obituaries

Yuen Sang Seto, M.D. (1900-1974)

His father Mon Kee came from China in 1870, an educated man who went on to California to be an interpreter for the Chinese coolies working there. He returned to China, picked up a bride and came back to Hawaii, where he settled in Kauai and started a rice plantation in Hanapepe. Yuen Sang was born there on March 24, 1900.

Yuen's father went on to found the first Chinese YMCA in Honolulu. He also started the first Chinese language school. He introduced terrapin from China for medical purposes and released them in the Wailua River on Kauai. In 1915, he opened a Chinese restaurant in Detroit, Michigan, so as to be near the eldest son and help him gain a law degree. Yuen's brother became the first Chinese lawyer in Hawaii and later on the first of Oriental ancestry to become a Shriner.

Yuen Sang, better known in life as Y.S., attended Iolani School and the University of Hawaii before going on to the University of Michigan for his B.S. degree and then his M.D., the latter in 1924. He served in World War I in the Student Training Corps at UH and in the Michigan National Guard as a Second Lieutenant.

After internship, followed by a residency in a tuberculosis sanatorium in Michigan, Y.S. returned to Hawaii and in 1926 opened up a solo private practice on Fort Street, opposite the old Princess Theater. From that day on Y.S. never left terra firma on Oahu.

In 1928 Y.S. married a girl from Kauai, Edith Nakamura, who was a graduate of the Normal school. She never had an

opportunity to teach school, however, as he made her a housewife, a mother, and his office assistant.

Y.S. did a fair amount of surgery, chiefly at St. Francis Hospital. In the Great Depression of the 1930's, he would often pay out of his own pocket the hospital expenses of his patients. He was offered the position of chief of surgery but turned it down. In 1948 he moved his office to the old York building on Queen Emma Square, and then in 1962 to 205 South Vineyard. It was only in January of 1974, having been a physician for 50 years, that he decided to limit himself to a half-time practice, with only his faithful wife to help him in the office. He remained a solo practitioner throughout his life, although two of his doctor sons, Millard and Dudley, had offices close by.

Y.S. suffered several episodes of serious illness but, typical of his self-reliance and independence, he resisted medical care and being a burden to others.

In 1955 he suffered a myocardial infarction but refused hospitalization and was back at work in two weeks. He never took a vacation from his practice, and the only time he ever closed his office was to sit at the hospital bedside of a very ill son—for three days!

Y.S. was a good member of several hospital medical staffs. He was also a member of the AMA, the HMA and the Honolulu County Medical Society but never sought high office. He had a greater interest in participating in and supporting the many Chinese benevolent societies, Iolani School and St. Andrews Cathedral. His main interests were in his practice, his family and his pigeons—in that order. He was widely known as a pigeon fancier and breeder.

Y.S. family was his pride and joy. The legacy he and his wife left thereby to the medical profession is considerable. Four of the six sons are physicians: Millard is board certified in ob-gyn, Dudley likewise in internal medicine, Dexter is associate professor of pediatrics at Johns Hopkins, and Anthony is a psychiatric resident at Barnes Hospital in St. Louis. The other two: Chauncey is a computer program specialist for the State of Hawaii, and Hugo is a vice-president and branch manager with First Hawaiian Bank.

Y.S. joined the Hawaii chapter, American Academy of General Practice in September 1951. He became Active Exempt in 1962, Inactive in 1969, and was accorded life membership in March 1972.

Dr. Yuen Sang Seto's distinguished 50-year-long career in medicine ended with his sudden and peaceful demise at home on August 8, 1974, at the age of 74. He had been planning to attend, with his oldest son Millard, his 50th medical school class reunion in October.

The Hawaii Academy of Family Physicians wishes to honor Dr. Y.S. Seto posthumously by this testimonial extended to his widow, his family, his colleagues and the community to which he contributed so much.

J.I. FREDERICK REPPUN, M.D.

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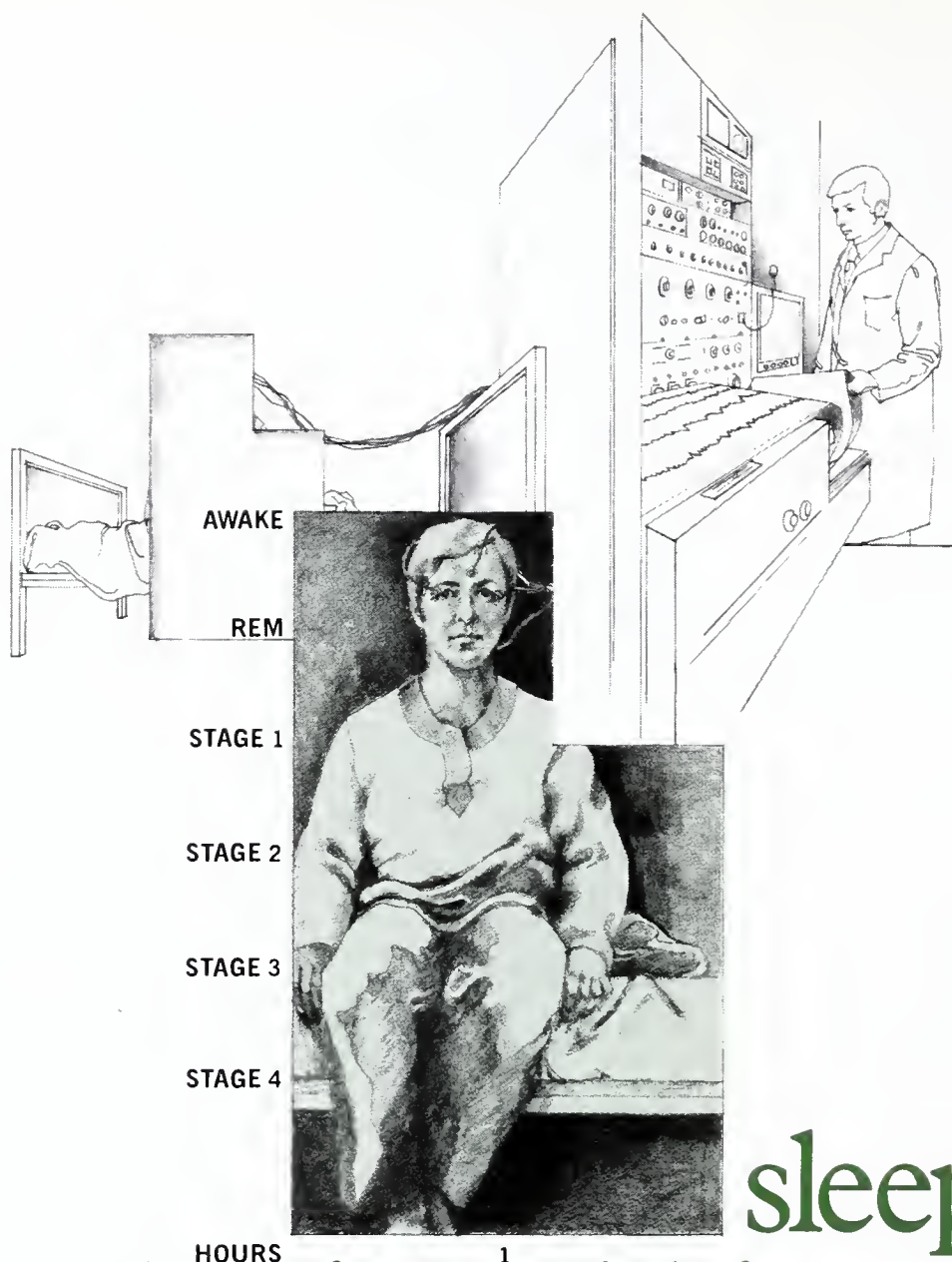
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to Fall Asleep (4 Studies,
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Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

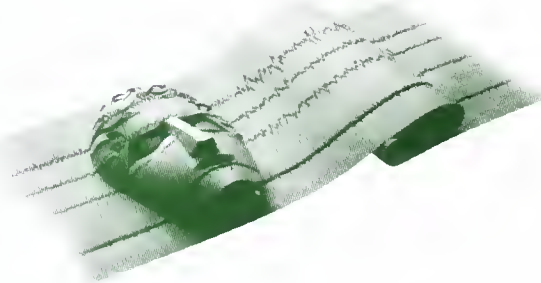
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5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ



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Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities.

Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently — both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Anti-hypertensive effects may be enhanced in post-sympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: Lomotil is contraindicated in children less than 2 years old. Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

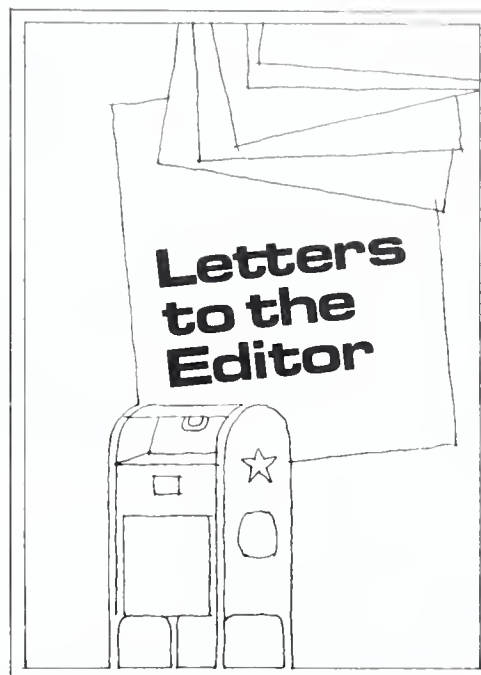
Dosage forms: Tablets, 2.5 mg of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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To The Editor:

It was distressing to read of the passing of Dr. F. J. Pinkerton. He was a dedicated servant to this community in many fields for a great number of years. Included in this service was his tenure as long-time president and director of the Blood Bank of Hawaii.

However, it would seem that it might be good to set the record straight at this time. In March 1941, the directors of the Chamber of Commerce appropriated \$2,000 from public health funds administered by the chamber to buy equipment and start a blood plasma storage center.

Earlier, after a proposal to the chamber by Dr. E. A. Fennel that a blood plasma bank be established, a study and organization plan was made by the Health Committee of the Honolulu Junior Chamber of Commerce, Dr. John W. Devereux, chairman; both men are now deceased.

The chamber directors, at the recommendation of Dr. Pinkerton, then chairman of the Public Health Committee, approved the Jaycees report and appointed the Honolulu Jaycees to coordinate and promote the new blood bank...

A successful informational and promotional campaign waged in the community by the Jaycees was instrumental in solidly establishing the Blood Bank. On Dec. 7, 1941, the bank not only had plasma and whole blood on hand but the know-how and equipment to handle the hundreds of civilian volunteers who readily responded to the call for blood. Many of the casualties that day owe much to this facility—perhaps their lives.

I hope this will clarify the origin of the Blood Bank. It in no way is meant to detract from the strong support given by Dr. Pinkerton in the early years and his many years as president. Rather it is meant to give unrecognized credit to the vision of Dr. Fennel and to the many long hours of devotion and volunteer time given by Dr. Devereux.

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Health Personnel in Hawaii, 1820-1974

ROBERT C. SCHMITT*, *Honolulu*

One of the most striking aspects of Hawaiian medical history is the high rate of growth in the Islands' professional health personnel. It was not until 1820, forty-two years after initial contact, that Hawaii had its first Western trained resident physician. Seventy-seven years later, on the eve of annexation, licensed physicians numbered 76. And after another seventy-seven years, in 1974, the total had increased to 1,309. This growth far exceeded the rate of increase in population.

The total number of professional and technical health personnel in the Islands has increased even more dramatically. The 1960 U.S. Census reported 4,122 civilians in Hawaii employed as physicians, dentists, optometrists, registered nurses, therapists, health technologists or technicians, or in similar work. By 1970 the total had increased to 5,800. While total population was growing 21.7 percent over this ten-year period, the number of health professionals increased by 40.7 percent.

Statistics on health personnel prior to 1884 are extremely rare and must for the most part be inferred from scattered historical accounts. Dr. Thomas Holman, Hawaii's earliest resident Western trained physician, arrived with the first band of American missionaries on April 4, 1820, and served in the Islands until October 2, 1821. Until that time, Hawaiians had had to depend on the *kahuna lapa'au* (traditional native practitioners) and occasional visits by ships' surgeons. The number of resident physicians apparently increased to two by 1830 and to six by 1840.¹ By 1853, the year of the smallpox epidemic, perhaps 17 American or European physicians were practicing in the King-

dom.² The first professional dentists soon followed, beginning with Dr. John Mott-Smith in 1851³ and Dr. John M. Whitney in 1869.⁵

The introduction of licensing requirements initially had scant effect on the compilation of medical manpower statistics. Licensing was instituted for foreign physicians in 1859⁵ and for all physicians in 1865,⁶ but it was not until 1897 that the first published figures on licensed physicians and surgeons—76, including one Chinese and several Japanese—appeared.⁷ Licensing was required for dentists under legislation enacted in 1892,⁸ for pharmacists in 1903,⁹ and for nurses in 1917.¹⁰ Except for one early total on licensed dentists (27 in 1904⁴), however, statistics on the numbers of licensed health professionals were published infrequently if at all during the early decades of the twentieth century.

Census statistics on medical and health personnel were first compiled in 1884. The Hawaiian census of that year reported 29 physicians and surgeons, four dentists, nine nurses, two veterinary surgeons, and 23 druggists at work in the Kingdom. These data were further cross-tabulated by race; the physicians, for example, included no Hawaiians, no Chinese, and 29 "others."¹¹

Census coverage of health manpower expanded considerably during the twentieth century. The number of professional and technical health occupations for which separate totals were published was four in 1900 and 1910, five in 1920, nine in 1930, eight in 1940, twelve in 1950, and 16 in 1960 and 1970. This increase in statistical detail coincided with a rapid growth in the number of health personnel. Physicians, for example, rose from 109 in 1900 to 341 in 1940 and 961 in 1970; dentists, from 21 to 401 during the seven-decade period; and

*Hawaii State Department of Planning and Economic Development
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TABLE 1.—Physicians, Dentists, Nurses, Pharmacists, and Veterinarians
Enumerated in Censuses of Hawaii: 1884 to 1970

CENSUS YEAR	MEDICAL PERSONNEL LIVING IN HAWAII ¹					PHYSICIANS PER 100,000 POPULATION ²	
	PHYSICIANS AND SURGEONS ³	DENTISTS	REGISTERED NURSES ⁴	PHARMA- CISTS	VETERI- NARIANS	HAWAII	UNITED STATES
1884	29	4	9	23	2	36	(⁵)
1900	109	21	14	(NA)	6	71	173
1910	128	22	165	(NA)	14	67	164
1920	160	41	251	(NA)	6	63	137
1930	255	132	707	(NA)	12	69	125
1940	341	196	1,080	76	20	86	126
1950	493	256	1,278	148	26	103	128
1960	717	378	2,091	156	29	124	131
1970	961	401	2,919	217	54	134	140

NA Not available.
¹Data for 1930 and earlier years refer to "gainful workers," either in civilian life or the armed forces, and may include persons not currently employed. Data for 1940 and later years refer to employed persons, excluding members of the armed forces.
²Based on total population before 1940 and civilian population for 1940 and later years.
³Listed as "physicians and surgeons" in 1960 and earlier years and as "physicians, medical and osteopathic" in 1970.
⁴Listed as "nurses" in 1884, "trained nurses" in 1900-1930, "trained nurses and student nurses" in 1940, "professional nurses" in 1950 and 1960, and "registered nurses" in 1970. Student nurses, included only in 1940, numbered 274 in 1950 and 129 in 1960.
⁵Not available. The U.S. rate was 171 in 1880 and 166 in 1890.
Source: *Census of the Hawaiian Islands Taken December 27th, 1884 Under the Direction of the Board of Education*; U.S. Census Office,

12th Census . . . 1900, Vol. II, Population, Part II, table 93; U.S. Bureau of the Census, *13th Census . . . 1910, Vol. II', Population, Occupation Statistics*, table V, pp. 294-295; U.S. Bureau of the Census, *14th Census . . . 1920, Population, Hawaii, Occupation Statistics*, table 10, pp. 7-8; U.S. Bureau of the Census, *15th Census . . . 1930, Occupation Statistics, Hawaii*, table 4, p. 9; U.S. Bureau of the Census, *16th Census . . . 1940, Population, Second Series, Characteristics of the Population, Hawaii*, table 13, p. 16; U.S. Bureau of the Census, *U.S. Census of Population: 1950*, Bulletin P-C52, table 53; U.S. Bureau of the Census, *U.S. Census of Population: 1960*, Final Report PC(1)-13D, table 120; U.S. Bureau of the Census, *U.S. Census of Population: 1970*, Final Report PC(1)-D1, table 221, and Final Report PC(1)-D13, table 170; U.S. Bureau of the Census, *Historical Statistics of the United States, Colonial Times to 1957* (1960), p. 34. The 1940 data for physicians and dentists and 1960 data for physicians, nurses and pharmacists are revised totals published in later census reports.

TABLE 2.—Medical Personnel Enumerated in the Census, by Sex, for Hawaii: 1960 and 1970

OCCUPATION	1970		1960	
	MALE	FEMALE	MALE	FEMALE
Total	1,914	3,886	1,539	2,583
Physicians, dentists, and related practitioners	1,448	232	1,267	119
Chiropractors	15	4	21	—
Dentists	381	20	374	4
Optometrists	28	—	54	—
Pharmacists	160	57	125	31
Physicians, medical and osteopathic	810	151	633	84
Podiatrists	—	—	31	—
Veterinarians	54	—	29	—
Registered nurses, dietitians, and therapists	196	3,085	101	2,214
Dietitians	11	85	8	58
Registered nurses	100	2,819	54	2,037
Therapists	85	181	39	119
Health technologists and technicians	270	569	171	250
Clinical laboratory technologists and technicians	90	274	71	109
Dental hygienists	5	18	—	16
Health record technologists and technicians	—	46	6	35
Radiologic technologists and technicians	70	109	66	66
Therapy assistants	—	9	3	—
Health technologists and technicians, n.e.c.	105	113	25	24

n.e.c. Not elsewhere classified.
Source: U.S. Bureau of the Census, *U.S. Census of Population: 1970*, Final Report PC(1)-D13, table 170.

professional nurses, from 14 to 2,919. Further information appears in Tables 1 and 2.
This growth in medical manpower far exceeded the increase in total population. The number of physicians per 100,000 inhabitants, for instance, increased from 71 in 1900 to 86 in 1940 and 134 in 1970. The Mainland ratio

stood at 173 in 1900, 126 in 1940, and 140 in 1970.
Intercensal and postcensal data on health manpower must be obtained from other sources. One such source is the Honolulu city directory, which since 1880 has contained listings of physicians, dentists and druggists, often

TABLE 3.—*Licensed Physicians (Including Military and Inactive) Living in Hawaii: 1897 to 1974*

DATE	NUMBER	DATE	NUMBER	DATE	NUMBER
1897: Nov.	76	1933: June 30	244	1968: Apr. 24	903
1919: June 30	133	1937: June 30	267	1969: May 1	930
1921: June 30	141	1963: Apr. 20	743	1970: May 1	989
1924: June 30	163	1964: May 16	766	1971: May 1	1,019
1926: June 30	175	1965: May	801	1972: May 1	1,070
1928: June 30	195	1966: June	845	1973: May 1	1,203
1930: June 30	206	1967: Apr. 19	875	1974: Aug. 8 ¹	1,309

¹Preliminary.
Source: *Pacific Commercial Advertiser*, Nov. 18, 1897, p. 7; *Report of the President of the Board of Health* (annual, 1910-1930); *Board of Health . . . Its Major Activities, 1933*; *Annual Report, Board of Health . . . 1973*; *Annual Report, Department of Health, Statistical Supplement* (annual, 1962-1973).

on an island-by-island basis.¹² Another source is the Health Department tabulation of licensed physicians, published annually since 1963 and at less frequent intervals back to 1919. These data, unlike those in the decennial census, include physicians in the armed services and those no longer active; recent tabulations, moreover, include breakdowns by sex, race, island of residence, and employment status.¹³ Trends since 1897 are traced in Table 3. Data on licensed physicians, dentists, nurses, and pharmacists have appeared annually since 1969 in *The State of Hawaii Data Book*.¹⁴ A national source with detailed data on health personnel by state is *Health Resources Statistics*, issued annually by the U.S. Department of Health,

Education, and Welfare.¹⁵ Some of these data are summarized in the *Statistical Abstract of the United States*.¹⁶

Statistics of this type are not only historically significant but are also essential for the proper planning of health manpower and facilities. Disaggregated by island and district, age and sex, and field of specialization, they permit new insight into health needs and resources. Cross-tabulated by data on professional earnings, they often prove useful for studies in medical economics. And from a historical point of view, they document the rapid progress of Hawaii from a primitive medical backwater to its present status as an area well served by a large and diversified community of health professionals.

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Giant Cell Myocarditis

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We have recently encountered two cases of giant cell myocarditis in two aged Hawaii Japanese women, each patient presenting with a problem of cardiac conduction. The process involved other organs as well. In one case lesions were found in the heart, lungs, liver, spleen, medulla oblongata, thyroid gland, diaphragm and lymph nodes. In the second case they were limited to the heart and lungs. They are reported because of the rarity of the disease and to bring attention to the associated extracardiac lesions.

Case Reports

CASE NO. 1:

This 90-year-old Japanese woman was admitted on September 28, 1971, because of shortness of breath. She had had a long history of hypertension and coronary insufficiency, and had been receiving a variety of medications, including pentaerythritol tetranitrate, Harmony (deserpidine), Elavil (amitriptyline Hcl), and Dramamine (dimenhydrinate).

She had shown a complete bundle-branch block, with idioventricular rhythm, since early 1971. She had had a cerebrovascular accident in 1962, with residual leftsided weakness, and a cholecystectomy for cholelithiasis many years previously.

On admission, she had basilar rales and slight edema of the legs. Vital signs: P 40, R 18, BP 254/90 and T 98.6°. A chest x-ray revealed moderate cardiomegaly and diffuse pulmonary congestion. The EKG revealed complete A-V block with idioventricular rhythm. CBC: hb 10.8 gm, hct 34%, and WBC 5,900 with differential count: stabs 1%, segs 71%, lymphs 15%, monos

9%, eos 3% and basos 1%. The platelet count was within normal limits. Serum electrolytes: pH of 7.40, HCO³ 31mEq/L, Cl 104 mEq/L, Na 142 mEq/L, K 3.7 mEq/L, BUN 18 mg%. Urinalysis: 4+ albumin. On the eighth hospital day she developed cardiac arrest during placement of a pacemaker. After the operation she remained lethargic. On the 21st hospital day she developed the second cardiac arrest and did not respond to resuscitative procedures.

Autopsy findings: The lungs weighed 750 gm. There were numerous grayish-white patches scattered over all the pleural surfaces, measuring up to 1 cm in diameter. On section these were found to extend into the lung parenchyma to form grayish-white, well-demarcated nodules. Others were also found in the deeper portions of the lungs. The heart weighed 320 gm. The epicardium was intact, smooth and shiny. The myocardium, from the pulmonary conus to the basal portion of the interventricular septum, was replaced by well-defined bands of grayish-white, firm tissue measuring up to 3 x 2 x 1 cm in width (Fig. 1). The intervening myocardium was pale tan and normal in consistency. The

FIG. 1. Granulomatous areas interventricular septum, Case 1.



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coronary arteries and valves were free of gross pathological changes. The liver, spleen, thyroid and lymph nodes in the mediastinum and abdominal cavity contained similar lesions. There were old cystic infarcts in the right cerebral cortex and the left cerebellum. The remaining organs were free of gross changes.

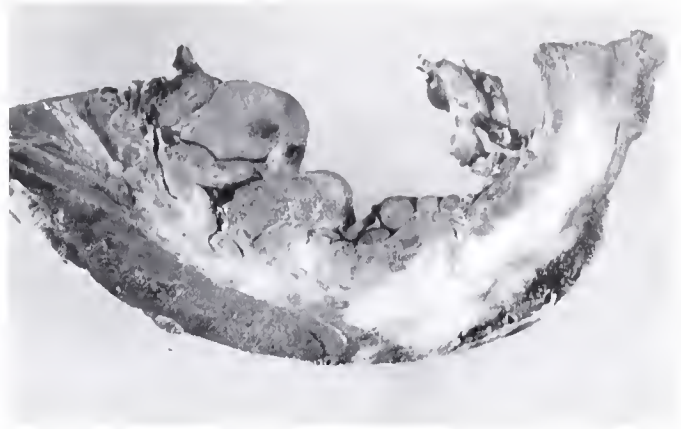
Microscopic examination of the myocardium revealed numerous granulomata, some with central coagulation necrosis. There were numerous Langhans' type giant cells, histiocytes, fibroblasts and lymphocytes adjacent to the areas of necrosis. The lesions in other organs were essentially similar to those seen in the myocardium. The granulomata in the lungs were most conspicuous in the walls of blood vessels in the subpleural connective tissue. Stains for acid fast bacilli and fungi were negative at all sites.

CASE NO. 2:

This 82-year-old Japanese woman was admitted on November 16, 1971, because of left chest pain radiating to the back, nausea and vomiting. A pacemaker had been inserted four years previously for complete heart block and had been replaced in April, 1971. The patient had been doing well until the morning of admission, when her family noted her to be sweating and short of breath. She had had subtotal gastrectomy, cholecystectomy and appendectomy in the remote past. In 1967 she had been hospitalized for chronic recurrent pancreatitis, essential hypertension, arteriosclerotic heart disease and left ventricular hypertrophy. The patient had been treated with Tigan, Metamucil (psyllium hydrophilic mucilloid), Harmony (deserpine), Mio-Pressin (rauwolfia serpentina, protoraterine and dibenzyl), Hydopres (hydrochlorothiazide and reserpine), Festal (digestive enzymes), Hormonin (estriol, estradiol and estrone), and Atarax (hydroxyzine hydrochloride).

Physical examination revealed clear lung fields. There were no cardiac murmurs. Her pacemaker appeared to be functioning adequately. On admission, vital signs were BP 124/80, P 68, R 22 and temperature of 98.2° C. CBC: hb 15.6 gm, hct 46%, WBC 11,400 with differential count of Stabs 6%, Segs 83%, Lymphs 7%, Monos 1%, Eos 3%. Serum electrolytes: pH 7.26, HCO₃ 21 mEq/L, Cl 94 mEq/L, Na 136 mEq/L and K 5.6 mEq/L. Serum amylase was 104 I.U. Urinalysis was within normal limits. Enzymes: CPK 72 units, LDH 1025 units, and SGOT 1940 units. BUN was 42 mg%, creatinine 2.7 mg%, alkaline phosphatase 35. The total bilirubin was 1.0 mg%, uric acid 13.6 mg%, total protein 6.4 gm% with albumin of 3.8 gm%. Chest x-ray revealed cardiomegaly and slight vascular congestion. The abdomen was essentially negative. The patient was placed on Cedilanid and Lasix as well as oxygen. Approximately nine hours after

Fig. 2. Granulomatous areas left ventricle, Case 2.



admission the patient went into shock. Aramine, Mannitol and Isuprel were given. There was poor urinary output. Blood gases showed PO₂ 99, PCO₂ 20, pH 7.30, hgb 15.5 gm and base excess of minus 15 mEq/L. Urinalysis showed albumin 3+, large amount of occult blood, 20-25 WBC/hpf, abundant RBC/hpf and abundant bacteria. Approximately 30 hours after admission the patient was pronounced dead.

Autopsy findings: The combined weight of the lungs was 1100 gm. The subpleural areas contained numerous pale yellow to grayish-white, firm and sharply circumscribed nodular zones, measuring up to 2 mm in diameter. They were most prominent along the basal margin of the right lower lobe. The heart weighed 410 gm. The right ventricle was dilated. The annulus fibrosus of the mitral valve was focally calcified. Bands of gray-white tissue were found in the interventricular septum and throughout all but a small portion of the anterior wall of the left ventricle (Fig. 2). The coronary arteries were free of occlusion. The valves were intact. The remaining organs were free of gross changes.

Microscopically, sections of the gray-white tissue of the left ventricular myocardium showed hyaline connective tissue which replaced the muscle fibers and were transversed by a few small capillaries. The tissues adjacent to these areas of fibrosis contained foci composed of Langhans' type giant cells, epithelioid cells and lymphocytes. They were not conspicuous in the perivascular lymphatic channels. The residual muscle fibers tended to be larger than usual. Microscopic examination of the subpleural nodules revealed some to be composed of confluent groups of epithelioid cells and Langhans' type giant cells enclosing a central zone of coagulation necrosis. For the most part, however, the foci were almost totally hyalinized and contained Langhans' type giant cells. A few small foci which were essentially similar in appearance were found in the perivascular lymphatic channels. The subcarinal lymph nodes were occupied

by groups of granulomata which were essentially similar in appearance to those noted in the lungs and heart. Stains for acid fast bacilli and fungi were negative. Microscopic examination of the liver revealed passive congestion with central necrosis of the liver lobules.

Discussion

Giant cell myocarditis is an uncommon disease first reported in 1905 by Saltikow¹. Since then, additional reports of similar lesions have been published. Palmer and his co-workers in 1965 reviewed 23 cases in the literature and additional cases were added by other authors^{2, 3, 4, 5, 6}.

According to many authors^{1, 4, 5, 6, 7}, the term, giant cell myocarditis, is identified with a myocarditis of unknown etiology characterized by necrosis, degeneration of the myocardial fibers, a granulomatous reaction and the presence of multinucleated giant cells. Earlier writers used the terms "idiopathic giant cell myocarditis", giant cell granulomatous myocarditis, isolated myocarditis⁸ and Fiedler's myocarditis⁹. Saphir¹⁰, however, in his review of myocarditis, stressed the distinction between giant cell myocarditis and Fiedler's myocarditis. The differential diagnosis of giant cell myocarditis must include tuberculosis, syphilis and Chagas' disease.

The etiology remains obscure, although a variety of causes have been suggested, such as a viral infection^{11, 13}, fungal infection^{12, 14, 15}, atypical type of sarcoidosis⁷ and hypersensitivity or auto-immune reaction^{10, 1, 8, 15, 16}.

Most of the early cases of giant cell myocarditis had no demonstrable cause²¹. Our own and previous attempts to isolate bacteria, fungi, and parasites have failed. The presence of extensive coagulation necrosis in our cases rules out Boeck's sarcoid. The vascular and myocardial distribution is not similar to that found with disseminated tuberculosis, although this cannot be entirely dismissed. Nodular tuberculoma has been reported to be a cause of A-V block¹⁷. In our cases, syphilis is less probable, although serological tests were not performed. The aorta was uninvolved and the inflammatory reaction did not contain plasma cells. Palmer and his co-workers¹ reported the first case of giant cell myocarditis associated with giant cell arteritis. He believed that multiple organ involvement and the presence of arteritis strongly suggested the presence of hypersensitivity or an autoimmune mechanism. In our first case, there were extensive vascular lesions, especially in the lungs. The distribution of lesions in this case resembles that which has been reported in association with hypersensitivity. There were no vascular lesions in the second case.

Giant cell myocarditis has also been reported in association with widely disseminated lesions in the viscera and skeletal muscle, as a part of a disease complex related to temporal arteritis and

Takayasu's disease. Unfortunately, the temporal artery was not examined in either case, and the aortas were free of granulomatous change. The fact that temporal arteritis occurs in old age makes this type of tissue reaction an attractive explanation of the disease process in our cases. It has been established that granulomatous lesions of the myocardium, liver, spleen, kidneys and blood vessels may result from hypersensitivity to sulfonamide drugs. Waugh¹⁸ reported a case of hypersensitivity to penicillin with sudden death. Histopathological studies revealed giant cell myocarditis. Similar lesions were found in other organs. In 1971, Barrett¹⁹ reported a case of allergic giant cell myocarditis complicating tuberculosis chemotherapy. Although none of these drugs were implicated in our patients, each had received a variety of medications during the last years of life.

Giant cell myocarditis mimicking tuberculosis may also be found in association with thymoma. Burke and his co-workers⁶, in 1969, reported giant cell myocarditis and myositis associated with thymoma and myasthenia gravis⁶. Although approximately one-third of the cases of this rare disease (10 cases) have been associated with thymoma, no such tumors were found in our cases.

The giant cells are thought to arise from two sources. Some appear to be of histiocytic origin and have the appearance of Langhans' or foreign body giant cells. On the other hand, some authors have thought that the giant cells were of myogenic origin, because cross striations can sometimes be demonstrated utilizing special stains. Pyun and his co-workers⁵ presented electron microscopic evidence suggesting that the giant cells are derived from degenerated myocardial fibers in 1970. Dilling, however, believed that these inclusions in the giant cells were phagocytized muscle tissue²⁰. Burke⁶ has also mentioned that they probably only reflect the severity of the inflammation. The concept of the myogenic origin of giant cells does not explain the presence of extracardiac lesions. Neither of our cases showed cross-striated material in the giant cells.

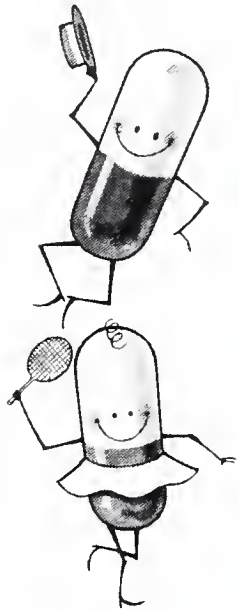
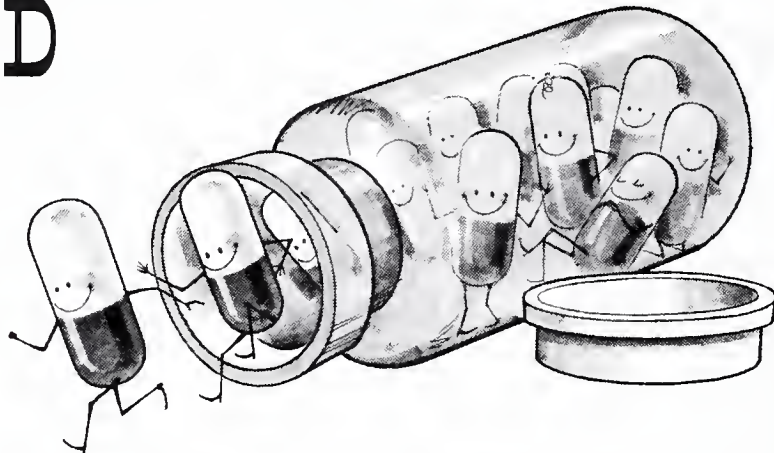
Summary

It is logical to assume that major disturbance of cardiac function in an octogenarian is due to degenerative vascular disease, but this is not always true. Two cases of giant cell myocarditis with extracardiac involvement are reported. One of them was associated with giant cell arteritis. Each patient was an aged Japanese woman who had developed disturbances of myocardial conduction. The pathological findings are presented and reports of other cases are reviewed and the possible pathogenetic mechanisms discussed.

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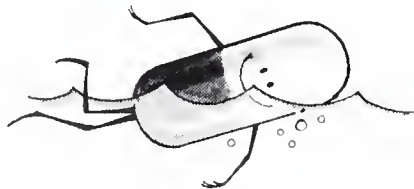
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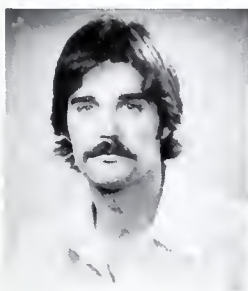
Gildo S. Soriano, M.D.

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Honolulu, Hawaii 96819
INTERNAL MEDICINE



Pauline G. Stitt, M.D.

University of Hawaii
1960 East-West Road
Honolulu, Hawaii 96822
PEDIATRICS



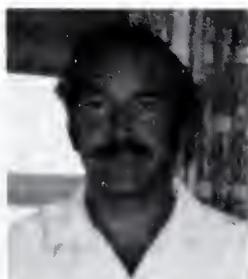
James M. Campbell, III, M.D.

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FAMILY PRACTICE



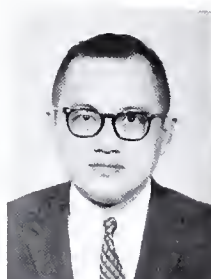
Mitsuaki Suzuki, M.D.

880 Kam Highway
Pearl City, Hawaii 96782
PEDIATRICS



Howard Keller, M.D.

30 Aulike Street
Kailua, Hawaii 96734
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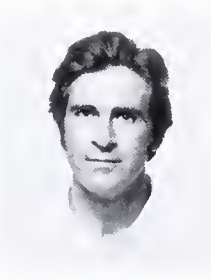
Lloyd Tom, M.D.

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Hilo, Hawaii 96720
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Wayne R. McKinny, M.D.

226 North Kuakini Street
Honolulu, Hawaii 96817
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Harry You Mun Wong, M.D.

1697 Ala Moana Blvd.
Honolulu, Hawaii 96815
OB GYN



Aloha, Ira Hirschy!

A career of 38 years, of which the first 5 and the past 23 were wholly devoted to leprosy and the 10 in between were partly so directed, came to a close last December with the retirement of Ira D. Hirschy, M.D., from the post of Chief of the Communicable Disease Division of the Hawaii State Department of Health.

Born in Woodburn, Indiana, raised in North Dakota, schooled in zoology and then in medicine at the University of Michigan, where he received his MD in 1933, Dr. Hirschy interned in the Canal Zone and then at Queen's Hospital, and became physician in charge at Kalaupapa Settlement in 1936. He remained at that post until relieved by Norman Sloan in 1941.

He then spent 4 years in the Army, much of it in India, 2 more with UNRRA in China, and 3 with SCAP in Japan, before returning to Hawaii in 1951 to take a post as Chief of the Leprosy Program.

In 1961, after 10 years in this position, he became chief of the communicable disease division, but leprosy remained, of course, his principal area of interest.

Of three sons by his first marriage, one, James, born in 1938, practices as a radiologist in New York City. The others did not go into medicine. Dr. Hirschy was married for the second time in 1959 to Dr. Emiko Sakurai.

Dr. Hirschy saw leprosy in Hawaii change from an endemic disease, with over 40 new cases a year locally acquired, to an imported one, with the same number of total cases but nearly all brought in from outside the state; and he saw it change from a life-ruining disease for which isolation was obligatory and treatment ineffective, to one which could be controlled almost always, and finally one which no longer required isolation. One of his last official acts was to announce that continued sojourn in Kalaupapa Settlement and Hale Mohalu Hospital was a voluntary matter for those patients still there.

It was his duty as medical officer in charge to resist efforts to eliminate isolation until there was proof that it was no longer necessary, and he did resist them, he finally took the decisive step of eliminating isolation completely for all time. With his retirement, an era draws to a welcome close.

HLA

Here We Go Again!

Based on a Maui County Medical Society resolution submitted to and adopted by the Council, the position of the Hawaii Medical Association on the Professional Standards Review Organization's (PSRO) law is: "Be it resolved, that the HMA be requested to go on record as opposing the PSRO law, while continuing, through The Foundation, to comply with the law until (it is) repealed or declared invalid, and to develop more refined Peer Review procedures for use when deemed advisable or necessary."

As physicians, our main concern about this law is that it may well reduce the effectiveness of the medical peer review mechanism that the profession instituted a long time ago and of its own accord. Also, the peer review in PSRO, being mandated by law and thereby compensable, will necessarily increase the cost of patient care, and this increase must eventually be borne by the patient, directly or indirectly. Thirdly, it will call for third party intrusion into the practice of medicine in ever increasing scope, and lastly the confidentiality of the medical and personal information shared by the patient and his physician will become almost impossible to preserve under the eye of Big Brother and his computer in Washington.

What we as a profession devised as a mechanism with which to police ourselves and, more importantly, to use for purposes of continuing medical education—true medical peer review—is now being turned against us. The government, being the largest of third parties and forever growing larger, the comptroller of the funds, naturally wants cost containment for its national health programs. The Bennett amendment, tacked on at the last moments of the 1972 session of Congress to a bill in favor of motherhood, succeeded in converting our medical peer review to the government's own ends through PSRO, an euphemism for cost containment via conformity to "standards".

The following are the principles upon which the A.A.F.P. has taken a stand as it faces up to PSRO. How do you stand?

- 1) An effective peer review mechanism is an essential part of quality health care delivery and that peer review can continue to be improved on the basis of physician-established guidelines;
- 2) There should be one standard of care applicable to all physicians in all specialties; these standards should be in accord with the general tenor of the guidelines of national specialty societies, but should be established by practicing physicians, and based on local needs. Local decisions must prevail. The omission of the performance of any portion of a guideline should not necessarily be interpreted as a breach of good medical practice nor should addition of services not included in a specific guideline be interpreted as inappropriate or unnecessary in the care of a specific patient;
- 3) The goal of peer review should be physician education and consequent improvement of patient care;
- 4) Punitive aspects of peer review may be necessary but should not be stressed except in their eradication;
- 5) Cost containment, while an important consideration, should in no way be allowed to dictate the quality of medical care;
- 6) Guidelines for care should in no way be restrictive with regard to physician qualifications other than criteria of training, experience and demonstrated competence; these qualifications should be established at the local level;
- 7) Guidelines for hospital admission need not be based only on diagnosis. Admission for reasons of medical problems, symptoms or physical findings may also be acceptable, and these criteria for care should be equally liberal for ambulatory care;
- 8) The confidentiality of the medical and personal record to which record both patient and physician contribute should be preserved from the prying eyes of third parties, except upon specific authorization for its release.

JIFR

Hospital News

Hilo Hospital

Hilo Hospital Medical Staff are struggling with the problems of expansion of need for services at Hilo Hospital subsequent to the increase in number of doctors on the staff. The additional general surgeons and specialty surgeons who have located in Hilo in the past two years have increased the volume of cases now handled at Hilo Hospital. A new short-stay surgery program has started. The surgeons hope that the fourth operating room can be put into regular service soon.

* * *

The South 2 surgical floor has been re-opened. It had been closed for five months because of shortages in nursing staff.

* * *

Two new committees have been added: a Tissue Committee chaired by Dr. Moon Soo Park, and a Timor Board chaired by Dr. William Spies.

* * *

Anesthesia coverage is now available for all deliveries; this had not been the situation before 1975.

* * *

A local effort to start a mother's milk bank, using the facilities of Hilo Hospital, has been rejected by the medical staff. It is considered unnecessary to have a milk bank on this island because of good air service from such facilities in Honolulu and San Francisco.

* * *

The CEA assay procedure is now available at Hilo Hospital for diagnosis of cancer and monitoring of cancer therapy.

A.W. MERTZ, M.D.
*Secretary, Hilo Hospital
Medical Staff*

Honolulu Hospitals

No news is good news?



Hawaii Academy of Family Physicians' Newsletter

J. I. FREDERICK REPPUN, M.D.

(In order to help strengthen the HAWAII MEDICAL JOURNAL and give it wider reader appeal from all segments of the profession, items in the HAFP Newsletter will be submitted to the HJM from now on.)

New Members—Patricia Diane DIETRICH MD on the house staff at QMC plans to start practice 1 July 1975 and is looking for a spot. Marc SHLACHTER MD is in practice at the Hauula Medical Center. He is a new Active member; Pat Dietrich is Associate member. Casimir JASINSKI MD who is the FAA Medical Director and is in private practice with his wife Doris next to the UH campus, is a new Active member.

Our Membership—as of 1 Dec 1974 included a total of 111, of whom 40 were "Fellows". We had 51 Active, 21 Active-exempt, 8 Associate, 7 Life, 6 Inactive and 18 student members. These were distributed: 10 on the Big Island, 10 on Maui, 3 on Kauai, 1 on Lanai and the rest on Oahu.

Changes—Albert SHIMAMURA MD, Active-exempt and Fellow, retired and his practice has been taken over by Ronald Perry MD, Internist. Albert was a member since 1952. Fred DODGE has given up his very active practice in Aiea in order to take on the Medical Directorship of the Waianae Comprehensive Health Center (Fred wants to try a new scheme of health care service). Vernon BOIDO MD has joined Fred in that government-sponsored enterprise. Gerald Kato, Advertiser staff writer in the 2 Feb Sunday paper's column "Follow-up" has described the hopes embodied in that project. We wish Fred & Vernon well and hope to receive input from them as regards progress and problems. By the way, Vernon made "Fellow" at the Denver convocation last October. Harold MACHIGASHIRA left the Windward Medical Clinic and joined Winfred Chang MD in the Kailua Professional Building. Chang is an internist; Harold is a Family Physician who does no Ob or surgery.

Members in the news—Noberto BAYSA MD of Wahiawa figured prominently as a member of a 3-man panel on "Emergency Medical Treatment" with Bill Wilkinson MD and Fred Holschuh MD on 22 January under the auspices of the HMA and the Hawaii Newspaper Agency—in Wahiawa. Don FARRELL MD got his name in the Sun Press for completing study requirements for membership and brought to the public what AAFP was all about. Gerald YORIOKA MD of Haleiwa wrote a letter to the editor (SB 10/16/74) pointing out that the USA's bad infant mortality standing is primarily due to the fact we record all losses practically from conception on!

HAFP 1975 Officers and Directors are—Pres. Doris JASINSKI, Pres-elect Don FARRELL, Sec'y Lincoln LUKE, Ties. Fred REPPUN, Directors to 31 Dec 75: Fred DODGE, Arch WIGLE, and Felix LAFFERTY who was chosen to replace

Rod MILLER who had to resign; to 31 Dec 76: Mary GLOVER, Bill BROWNLEE replacing Lincoln LUKE, and Harold MACHIGASHIRA; to 31 Dec 77: Les VASCONCELLOS, Pat WALSH and Gerald YORIOKA.

The HAFP Council—holds its meetings regularly on the first Thursday of each month at the Kauaikeolani Children's Hospital for lunch at 12:30PM. All members are welcome to attend.

Special—Larry WONG MD, Active and Fellow was elected Chief of Staff and President of the Executive Board at St. Francis Hospital. Bob Ballard is chief of the general practice dept. Congratulations, Larry!

Also Special—Felix LAFFERTY MD has been re-appointed to the Mental Health Committee of the A.A.F.P. We hope Felix will again run for election to the Board of Directors of A.A.F.P. in the Fall of 1975, and we pledge him our support.

Credit Hours—As you should know by now, Active-exempt membership status is no longer attainable, but those already so categorized may retain that status; they are requested to obtain credit hours on their own.

Active members must record 150 hours each three years. From now on, 75 of these hours must be in category "P". However, during the transition period the requirements are as follows:

Those who were up for re-certification	31 Dec 1973—	50 hours of "P"
"	31 Dec 1974—	58 hours of "P"
"	31 Dec 1975—	67 hours of "P"
"	31 Dec 1976—	75 hours of "P"

and thereafter. Please remember that if a seminar, lecture or course is categorized as "I" by the AMA towards its Physician's Recognition Award (PRA) it does not necessarily qualify for "P" by A.A.F.P.

Watch the pages of the Hawaii Medical Journal for future credit hour courses. (You have a listing of the courses applicable for your records in 1974; SAVE THEM FOR REFERENCE! You can always check off the ones you attended and mail them back to Jean Reppun, Exec. Sec. to file in your folder.)

CORE CONTENT—Hawaii is 4th in the nation in terms of the percentage of its membership taking the self-examination, 6-month course called Core Content Review—23.9%. Connecticut, Alaska and Ohio are 1, 2, 3.

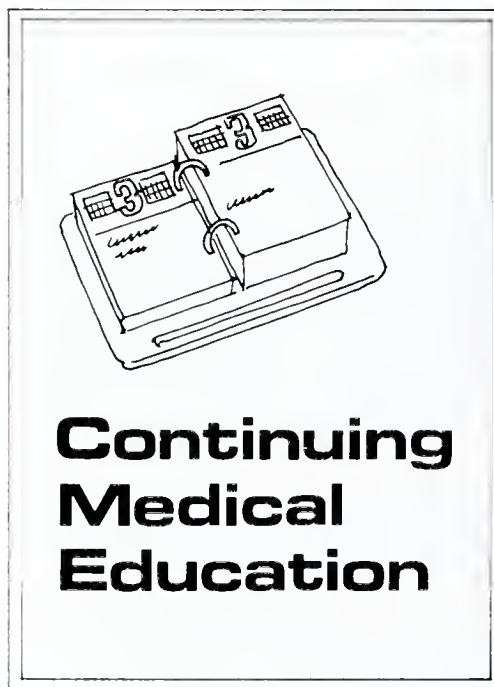
HAFP Committee Chairmen are—Membership—Doris JASINSKI, Mental Health & Public Relations—Felix LAFFERTY, Health Care Services & Public Health—Mary GLOVER, Education—Fred DODGE, Public Affairs & Legislation—Howard LILJESTRAND, Cancer Research—Don FARRELL, By-Laws—Roscoe PEBLEY & Fred REPPUN.

Tom Stern MD—Director, Division of Education, A.A.F.P. was a guest of HAFP and particularly of Col. BROWNLEE at a gathering of some of the officers and councillors at the

Jasinski home on 11 Jan 75; also invited was Bob Worth MD of the UHSchPubHealth and Tom Whelan MD, Director of Educ at QMC (Surgery) and chm of the Task Force to study the setting up of a Family Practice Dept at UHSchMed and a Family Practice Residency Program. Terry Rogers, Dean, UHSchMed was unable to attend. Members present were: BROWNLEE, FARRELL, HALL, JASINSKI, LAFFERTY, L. LUKE, REPPUN, SLOAN, TABRAH and YORIOKA.

A.A.F.P. is aiming for 4,000 graduates from medical schools to go into Family Practice (25% of all graduates) and into 400 Family Practice Residencies. Currently there are 225 such programs. Of 1,200 some odd grads this year, 93% will be placed in appropriate slots. 57% of those coming out of Family Practice programs went to practice in communities under 30,000 in population.

JIFR



Continuing Medical Education

ELIZABETH K. ANDERSON, M.D.

Kapiolani Hospital will be surveyed by an HMA Accreditation team for accreditation on March 4, 1975. Applications continue to be received from other institutions.

CALENDAR OF ACCREDITED EVENTS

(One unit AMA credit for CME for one hour of program excluding 'breaks')

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Local:**On-Going:**

- Kauikoolani Children's Hospital:
1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program
4. April 2-4, Post-Graduate Pediatric Symposium

Special Events:

February 15-22—2nd Annual "Advances in Patient Care"
(Design and Use of Protocols)
Conference Center, Waikiki Resort Hotel
Sponsored by Medical Computers Service Association of Seattle, PHRI, American Society of Internal Medicine, Straub Clinic.
(15 units Category 1 AMA; 15 units credit AAFP)

February 15-21—Pan-Pacific Surgical Society Meeting—
13th Congress
Sheraton Waikiki Hilton Hawaiian Village Hotel

February 23— "Seminars in Sexual Counseling"—Brief
March 1 Therapy Approaches to Office Management of Sexual Problems
Princess Kaiulani Hotel
American College of Ob-Gyn, Kapio-lani Hospital
(also March 16-22, April 13-19)

March 16— "Management of Heart Disease in Elderly" at Straub Clinic Conference Room; sponsored by Western Division American Geriatric Society
(6 units Category 1 AMA credit; 6 units Class II AAFP credit)

Last week in— "Symposium on Sleep Disorders" by
March William C. Dement, M.D., Ph.D. and Stanford University Sleep Disorders Clinic
Mabel Smyth (tentatively)
Sponsored by Hawaii Psychiatric Society and HMA

April 13, 14— "Update on latest developments in Internal Medicine"
Kahala Hilton; Hawaii Regional Meeting
American College of Physicians (contact Bernard Fong, M.D.)

California-Sponsored Courses in Hawaii:

April 5-10— Orthopedics—USC at Mauna Kea Hotel, Kamuela, Hawaii

April 5-12— Pediatrics—USC at Kona Surf, Kona, Hawaii

April 21-25— Emergency Medicine—USC at Kona Surf, Kona, Hawaii

April 21-25— Diagnostic & Therapeutic Skills, USC at Mauna Kea Beach Hotel, Kamuela, Hawaii

April 26— Management of Surgical Patient—Stanford at Mauna Kea Beach Hotel, Kamuela, Hawaii
March 3

Out of State:**AMA Regional CME Programs—8 Courses offering Category 1 credit**

- 1) Dermatology for Non-dermatologists
- 2) Infectious Diseases & Antibiotics
- 3) Fluid & Electrolyte Balance
- 4) Venereal Disease
- 5) Pulmonary Function & Blood Gases
- 6) Basic & Advanced Support CPR
- 7) Basic ECG
- 8) Human Sexuality

at:

- a) Tampa, Florida (Feb. 8-9)
- b) Phoenix, Arizona (Mar. 15-16)
- c) Minneapolis, Minn. (July 26-27)
- d) Williamsburg, Virginia (Sept. 27-28)

For further information, write:

American Medical Association
535 North Dearborn Street
Chicago, IL 60610

April 21-25— ACP Course "Recent Progress in Clinical Endocrinology: Physiological approach to Diagnosis & Treatment"
Ann Arbor, Michigan

April 21-25— ACP—Physiological Basis for Management of Respiratory Insufficiency; Charleston, South Carolina

For further listings of numerous Category 1 accredited CME courses in California and other states, see CME Bulletin Board at the HMA Office of CME, and refer to the JAMA special issue on continuing medical education.

Other:

For listings of weekly lectures and rounds of not yet accredited local institutions, (but hours attended can be applied as Category 5 credits) see CME Bulletin Board at the HMA Office. We have the weekly lecture/rounds seminar topics of Kuakini, St. Francis, Queen's and other institutions posted as they are received.

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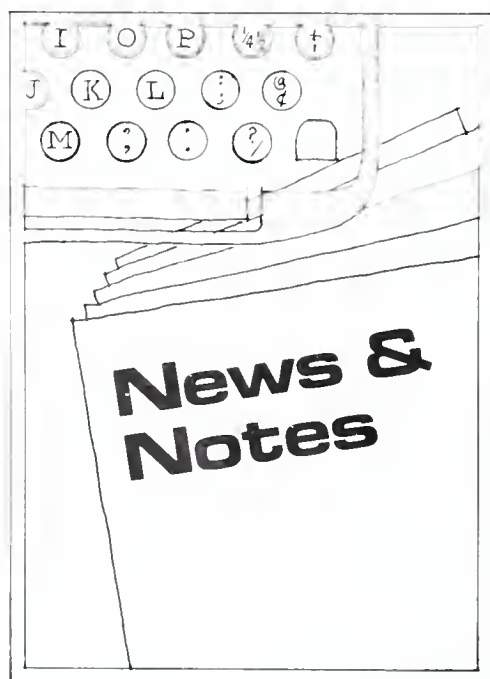
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HENRY N. YOKOYAMA, M.D.

Life In These Parts

Health officer **Alice Broadhurst's** epic battle with the mice of Kihei was turned into a horror story by the *National Enquirer*, a weekly from Carmel, California: "Night-

mare Island" (in bold bold print) "Millions of Mice Go on Rampage at Hawaiian Resort" (in less bold print) "Starving mice—millions of them—are creating a nightmare in the Kihei resort area... Since August, great hordes of the creatures have been scurrying down the slopes of Haleakala in a desperate search for food..." Alice was quoted as saying: "We've dumped 2,000 pounds of poison in the forests behind Kihei... We've been killing mice by the thousands, but they're coming in by the millions—we can't stop them." A Maui resident was quoted as saying, "I've never seen anything like it! When you go outside they come at you—five or six at a time—they get all around your feet!" (Sounds like the script from an Alfred Hitchcock shocker.)

We gleaned the following from Tom Horton's column: "Pacific Club being long on tradition, **Dr Jack Scaff**, the marathon runner who trains on Primo, wasn't surprised to find the old-style 11-ounce Primo still selling at the P.C...."

Bob Weiner presented a certificate to a Tsugie Shibata, the 5,000th woman to go through the Breast Cancer Detection Demonstration Project in Honolulu. Project director **Fred Gilbert** reported that of 5,000 women examined last year, 131 biopsies were recommended and 72 performed. Eleven cancers were diagnosed and treated with mastectomy...

About 1,800 surgeons from 24 countries will meet in the Hilton Hawaiian Village Feb 15 through 21 for the 13th Congress of the Pan Pacific Surgical Association... The announcement says, "The sessions will feature 400 speakers discussing heart and cancer surgery to sex problems and acupuncture." (We mulled over the last sentence—did it mean sex problems are caused by acupuncture or acupuncture is curative for sex problems, or... what the heck!)

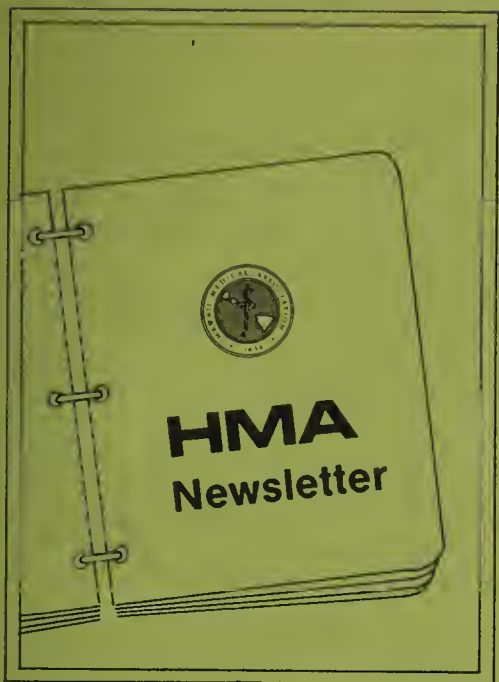
Insurance companies dropped their malpractice coverage in at least seven states recently... Our HMA executive **Tom Thorson** reported on the state of the union... "We're okay so far, but if the deluge continues, we'll go down the drain with the rest of them... Hawaii seems to be the only bright spot... This is the only place that premiums were reduced last year..." And Tom attributes this to the close working relationship between physicians and Argonaut through the peer review board...

The *Maui News* recently carried an editorial, more in the nature of a memo to our new State Health Dept head: "The State Health Department here on Maui has been operating short-handed, understaffed and with a steadily growing workload. As a consequence, Mauians have been playing footsie with any number of dangerous situations and most of us unaware... The District Health Officer here on Maui has kept it no secret, her department is short, the problems are growing and in situations, Mauians are peacefully sitting on a health time bomb... Maui has not sent a memo, but bold black headlines... They should do the trick." (Methinks the *Maui Press* is hankering to get a message to George Yuen... Lesser men would be offended by such tactics...)

Psychiatrist **Robert Spencer** of the Mental Health Division in Maui was married on Dec 28, last seen on Dec 31, reported missing Jan 8 by Bruce, his son, and found dead Jan 10 by a police helicopter searching the vicinity of his abandoned car on Ulupalakua Road. The terse announcement says "Police do not suspect foul play..."

Dale Adams, cardiologist with the Windward Medical Center, lives in Waikiki and cycles to work via the Pali and returns home by way of Waimanalo-Mokapu. Dale who rides a Lejeune (French racing bike) averages 20 miles an hour but coasts through the Pali tunnels and downhill at 45 mph (the speed limit). He logs 40 miles a day. Describing the thrills of cycling, he describes it as "a natural high—exhilaration induced by exercise." But he admits, "I can do a lot of ancillary thinking, but any time I take my immediate attention off what I'm doing, I get in trouble. Some dog may run at me or a coconut might roll into the

continued on page 69



H. TOM THORSON

Physicians intending to increase their deposits into the Keogh Plan are advised to consult with their attorneys and tax accountants before making the changes. Unfortunately, the Hawaii Code does not permit such an increase. Whether or not the legislature will correct our Code, in order to conform to the federal code, is not known.

* * * *

Malpractice Insurance problems continue to be high on the list of priorities. Senator Inouye and Senator Kennedy have introduced a joint bill relating to compensation for medical injuries. This is a form of "no fault" type insurance—just how it would work and what the cost would be is completely unknown. The AMA is working toward a similar end. The probability of any results from this activity soon enough to meet the present situation is remote. Also—it just may make matters worse.

* * * *

PL 93-641 is the number of recent legislation consolidating Comprehensive Health Planning (CHP), Regional Medical Programs (RMP), and the Hill-Burton agencies under one head, along with the creation of a Health Systems Agency and Health Service Areas throughout the country. HMA was represented at a recent meeting relative to the new law that was held in San Francisco. Creation of the structure is mandated to be completed within four months with the operating guidelines approximately eighteen months away.

The AMA has filed suit questioning the constitutionality of the law on the grounds that it invades the rights of the several states. Details

of the suit will be made known as they become available.

The Nurse Training Act of 1974 was vetoed by the President.

The Health Revenue Sharing and Services Act of 1974 was also vetoed.

The Health Manpower Act died in conference.

Still pending is H 15090 amending the PSRO law along lines suggested by the AMA.

* * * *

Testimony before legislative committees proceeds with prepared material being presented relative to the Medical School by Dr. Winfred Lee, President of HMA. HMA's position supports the medical school as a degree-granting school with many benefits to the community, with the condition that it be supported by the state with sufficient funds to make it a first class school.

A whole series of study resolutions relating to many subjects concerning health matters will be considered. HMA in general supports such an evaluation program and has requested input into the study program. One of the problems is the Medicaid-Medicare program. Adequate funding for a reasonable payment schedule has been avoided since 1967. A concerted effort is being mounted to obtain a more equitable approach to the cost of care for Medicaid recipients. A committee headed by Dr. Chew Mung Lum has been appointed to work with DSSH on fee changes.

* * * *

AMA-HEW contract for training programs for Medical Directors of long term care facilities will not reach Hawaii but HMA is working out a plan for such a program to be held in Honolulu this fall. AMA contract provides for a session to be held in each region with the Region IX program to be held in California. More will be announced on this at a later date.

* * * *

"Fat Farms" using HCG are out of bounds. Physicians associated with the so-called reducing salons using the hormone preparation could be subject to penalties under both state and federal law.

* * * *

Peer Review problems and activities are a major activity in all counties and state committees. The Professional Liability Committee is concerned with problems relating to coverage and liability. New problems are cropping up in

all counties and require resolution. It is apparent that the functions of the peer review committees will become more demanding and more complex in the future requiring a greater degree of formalization of procedure. Problems range all the way from charges of negligence resulting in death all the way up to the use of language that is offensive to the patient. Fees, services, and doctor-patient communications seem to be in the forefront of the conflict. The Professional Liability Committee tries to be the doctor's advocate in working with the insurance carrier but sometimes the doctor in question becomes his own worst enemy by refusing to cooperate. Some of the problems presented are:

- Patient complained because he went to the physician supposedly suffering from the "flu", was subjected to several hundred dollars worth of x-rays—was referred to a specialist who could find nothing in the x-rays to support the original physician's findings—finally was told that he had the "flu" and given a prescription for cough syrup. Who is right?
- Doctor used "lurid" language in discussing sexual problems as a possible cause of headaches. Patient was insulted. What actions are indicated?
- Cardiac arrest resulting in death while under anesthetic. Record does not establish proper monitoring by anesthesiologist.
- Patient complaint about excessive fee for surgical procedure was reviewed by the committee and it was found to be a computer error!

* * * *

Handbook For Committee Chairmen will be published shortly. It is designed to assist the committees in their functions. More will be coming up later in the form of policy statements covering HMA positions on various subjects.

* * * *

Hearing impairment program to be given by Library for the Blind and Physically Handicapped at 402 Kapahulu Avenue, March 1, 1975. This will be an all day program—8:30 AM-3:30 PM. Morning to be devoted primarily to films and afternoon a panel discussion on working with individuals having a hearing problem. (Received too late for listing in meeting schedule.) Contact Carol Sanders, phone 732-7767.

* * * *

Airforce needs doctors—scholarships for medical students are available as well as appoint-

ments for active duty. Contact Kenneth J. Mackie, Jr., Capt. USAF, MSC, 620 Central Avenue, Alameda, California 94501.

VA Outpatient Clinic is badly in need of a Generalist. Contact Dr. M. J. Schluskel, Director, Outpatient Clinic, Veterans Administration, Phone 546-2174.

* * * *

Applications are being received for the position of Hawaii District Health Officer to administer Department of Health programs on the Big Island. The requirements for the position are a medical degree, one year internship, 3 years of experience as a physician including two in public health, 1 year of graduate work in public health or substitution of a year of experience, and a Hawaii medical license. Interested physicians please contact Dr. Audrey Mertz, 548-6505, 548-7404 or 548-7406.

* * * *

Family Practice examinations will be given November 1-2, 1975, at five centers in US. For further information contact Nicholas J. Pisacano, MD, Secretary, American Board of Family Practice, Inc. University of Kentucky Medical Center, Annex 2, Room 229, Lexington, Kentucky 40506.

* * * *

American College of Chest Physicians calls for abstracts for papers to be given at annual meeting—Anaheim, California, October 26-30, 1975. Contact W. Gerald Rainer, MD, Chairman, Scientific Program Committee, American College of Chest Physicians, 911 Busse Highway, Park Ridge, Illinois 60068.

* * * *

HMA will testify relative to DSS budget and proposal before legislative committees. Thrust of testimony to the effect that failure of DSS to meet cost of care is depriving recipients of free choice. DSS agreed in 1967 to work toward improved fee schedule but nothing has happened since. DSS expresses satisfaction with degree of participation by profession—not much concerned with satisfaction of profession, judging by performance.

road... It takes almost total concentration to keep out of trouble..."

A 10-month study of blood samples from nearly 1,000 Oahu school children from Sep 1 1973 to Jul 1 1974 by the U of H Medical School's Dept of Tropical Medicine and Medical Microbiology shows that a high percentage of island children are susceptible to measles, mumps, rubella and Type III polio. More specifically, 14% for Type III, 15% for rubella, 21.7% for measles and a high 47% for mumps.

Aldon Roat, chief of the State's mental health division testified at recent legislative hearings. "While there are many good things that can be said about patient care at Hawaii State Hospital... it is also true that in other respects patient care has been marginal for years." Aldon said there are profound management deficiencies, especially in regard to long- and intermediate-term planning and "thus problems tend to be resolved on a crisis basis rather than prevented through advance anticipation." But then Robert Eisler from the same mental health division urged that the State Hospital be phased out and that general hospitals care for those needing hospitalization. Robert argues that even a massive advertising campaign could not change the hospital's frightening image with the Hawaii community...

A local survey asked the key question in 600 random personal interviews: "Would you have confidence in a statement made by leaders in the following areas." The results were as follows:

24% Land developers	51% Sugar industry
39% Advertising	53% Newspapers
40% Big Five	53% Tourist industry
41% Organized labor	55% Lawyers
45% State government	62% School teachers
47% Big companies	63% Judges
48% Pineapple industry	67% Banks
49% Retail stores	67% Television news
50% Organized religion	69% University of Hawaii
	74% Medical profession

(Which simply goes to show that we can fool some of the people some of the time, but not all of the people most of the time...)

Tom Thorson's Corner

J.G. was using the restroom in Pittsburgh when the stranger next to him turned to him. "Bet you're from Philadelphia." "Why, yes! How did you know?" "And I bet you're from Rabbi Weinstein's synagogue?" J.B. was even more astonished. "Right again... But have we met before?" "No, but Rabbi Weinstein always cuts at a bias, and you're peeing on my shoe..."

Professional Moves

The Year of the Rabbit is upon us. We pray that it bring good fortune and harvest to all, even the Feds... In January, **Fred Dodge** was appointed medical director of the Waianae Coast Comprehensive Health Center (at last report, Fred was still commuting between his Aiea office and Waianae); **John Morris** joined the Internists Clinic Inc at 1441 Kapiolani; internist **Mark Kuge** joined The Honolulu Medical Group at 550 So Beretania St; OB man **Kenneth Pruett** joined the Straub Clinic & Hospital, Inc; plastic surgeon **Marco Rizzo** opened at 1150 So King; and GP **Harold Machigashira** opened at Kailua Professional Building, 30 Aulike St. On Lanai, **James Langworthy**, formerly with the Straub Clinic, will replace E.D. Willett, who had been working under a Straub Clinic contract. James says that he expects to remain as Lanai's sole physician permanently to serve the island population of 3,000 employees of Dole, Lanai Co and affiliated enterprises...

Hors De Combat

In November, while **Clarence Chang** was out to lunch, two men entered his office at 33 S King and took \$325 from his receptionist and tied her up. They then took \$9,000 in cash and \$1,000 in jewelry from a patient who had just come from the bank. Still not satisfied, they sacked his office and took another \$425 in cash and some Seasonal... Another physician's office on South King was burglarized in November of 1,500 pills of which 1,000 were antiseptic pills containing fatal amounts of cyanide.

Despite the vigorous fluoridation campaign by the local medical and dental societies, the Health Dept and the ILWU, the Big Island voted down fluoridation by a margin of 4 to 1, or more specifically, 21,727 to 5,011.

The California State Supreme Court recently decided that psychiatrists and psychotherapists have a legal duty to warn the intended victims of patients they conclude are dangerous... The court ruled by a 5-2 decision that there was such a duty to warn and that the warning would not violate the privilege of confidentiality... The dissenting opinion, written by Justice William Clark, warned that "the decision would have a devastating impact in the field of mental health"... Psychiatrists fear that from now on the dangerous patient may not accept therapy if he thinks his confidential statements may reach the ears of police or a potential victim, real or imagined...

Back in September last year, **Bill Stevens**, medical director of the Counseling Clinic, was up in arms when a feature story of psychiatrist **Fred Weaver's** sex clinic was headlined, "Psychiatrist to Open New Sex Clinic Here." Bill said, "people will think that Honolulu doesn't have modern sex therapy clinics... Modern sex therapy has been alive and well here for some time in several local clinics staffed by well trained and qualified professionals, including physicians and psychologists. They incorporate the latest methods of Masters and Johnson and other leading sex research centers on the Mainland, and offer prompt and effective help for sexual dysfunctions at an average cost far less than a Mainland trip."

Back in December, **Audrey Mertz**, then district director of the State Health Dept, reported that a Ms Barbara Fairchild of Honaunau will be charged with three criminal counts for allegedly practicing midwifery without a license on the Big Island...

The State Office of Consumer Protection warned local physicians to disregard bills for a \$185 subscription to an international medical directory of physicians from the Mayo Research and Publishing Co of Hong Kong. Fortunately no-one has fallen for this solicitation... we hope...

Pathologist-hotel-owner **Dick Kelley**, who runs the Outrigger Hotel in his spare time, reports that his job is like manning an airport control tower: "I've got 60 tourists in a holding pattern downstairs while I get their rooms off the ground."

The *AMA News* reported in November that "Not one cent of any AMA member's dues money ever goes to any political candidate..." and further elucidated, "It is the American Medical Political Action Committee that raises money to support candidates." The intent of the announcement was to dispel any notion that the recent \$60 dues increase was to go into political funding...

Quotable Quotes

(By *Edgar Childs*)

"Diet is necessary for someone who exceeds the food limit."

"Definition of a hermaphrodite: Bisexual built for two."

"Heaven is to live in London with a Japanese wife and a French cook on an American salary."

"Hell is to live in Paris with an American wife and an English cook on a Chinese salary."

continued on page 70

Related Sports Stories

Bill Dang reports that one Sunday morning in May, Calvin Kam just barely missed a hole in one on slow-playing Henry Fong as he was bent over. Bill reports that Gabe Ma and John Takamura were witnesses...

In the recent grueling 26-mile Honolulu Marathon held in December, the Hunky Bunch (eight of them) won seven trophies. The trophy winners were Daven, Jerry, Hunky, May, June, Joy and Connie Chun... But alas!, where was Hunky Chun himself when the trophies were being issued?

Community News

The Board of Trustees of G.N. Wilcox Memorial Hospital established a scholarship fund in memory of Sam Wallis for the education of Kauai students pursuing careers in medicine or allied health professions.

How do you eulogize a man like F.J. Pinkerton who while living received more honors than any physician we know? F.J. in his 82 years received personal citations from Presidents Roosevelt, Eisenhower, Johnson and Nixon. Last year he received Hawaii's Native Born Citizen of the Year award... He received the coveted Order of the Splintered Paddle from the Honolulu Chamber of Commerce in 1965. He was co-organizer of the Pan Pacific Surgical Association in 1928. He helped establish the Blood Bank in 1941... How do you eulogize such a man? Words and phrases simply cannot...

Elected, Appointed, Honored

We are happy to note that a physician finally made it... Personable Richard Wasnich, age 32, director of Kuakini's Nuclear Medicine Division, was one of the winners in the recent Hawaii State Jaycees annual "Three Outstanding Young Men" award.

The Citizens for the Preservation of Kalaupapa includes Claude Caver, Ira Hirschy, and Richard Lee among its directors... When the 125th annual meeting of the Chamber of Commerce convenes, Masato Hasegawa, chairman of the Chamber's election judges, will announce the results of balloting to elect seven new directors... Donald Farrell of Kaneohe recently completed continuing medical education requirements to retain active membership in the American Academy of Family Physicians... Cesar de Jesus of 24 Poipu Dr won the best in the religious category in the annual Hawaii Kai Christmas Home Lighting and Decorating Contest... Wayne Wong, who received his MD degree from Rush Medical College, Chicago, Illinois, and now has three sons in that college, was recently elected a trustee at Rush-Presbyterian-St Luke's Medical Center.

Bulletins

Med History 606 "Seminar in the History of Medicine" 6 pm Tuesdays (Feb to May) Seminar Rm; Pathology Dept, 5th floor, Biomedical Bldg, Manoa Campus, UH; Call Charley Judd (open to all interested physicians)

Tumor pathology; every Monday, 1 to 2 pm; Kuakini Hospital; Grant Stemmerman; starting Feb 3 with "Pathology of Gastric Carcinoma"; interesting correlation of pathology and clinical material. (Open to all interested physicians.)

Miscellany

Doc Smith was late for his golf date and was rather curt with patients whose phone calls kept delaying him. Next morning, his nurse was being constructively critical: "Doctor, several patients were upset when you cut them short yesterday." A patient who had been scheduled for circumcision hurriedly departed from the waiting room... (Contributed by Bill Dang)

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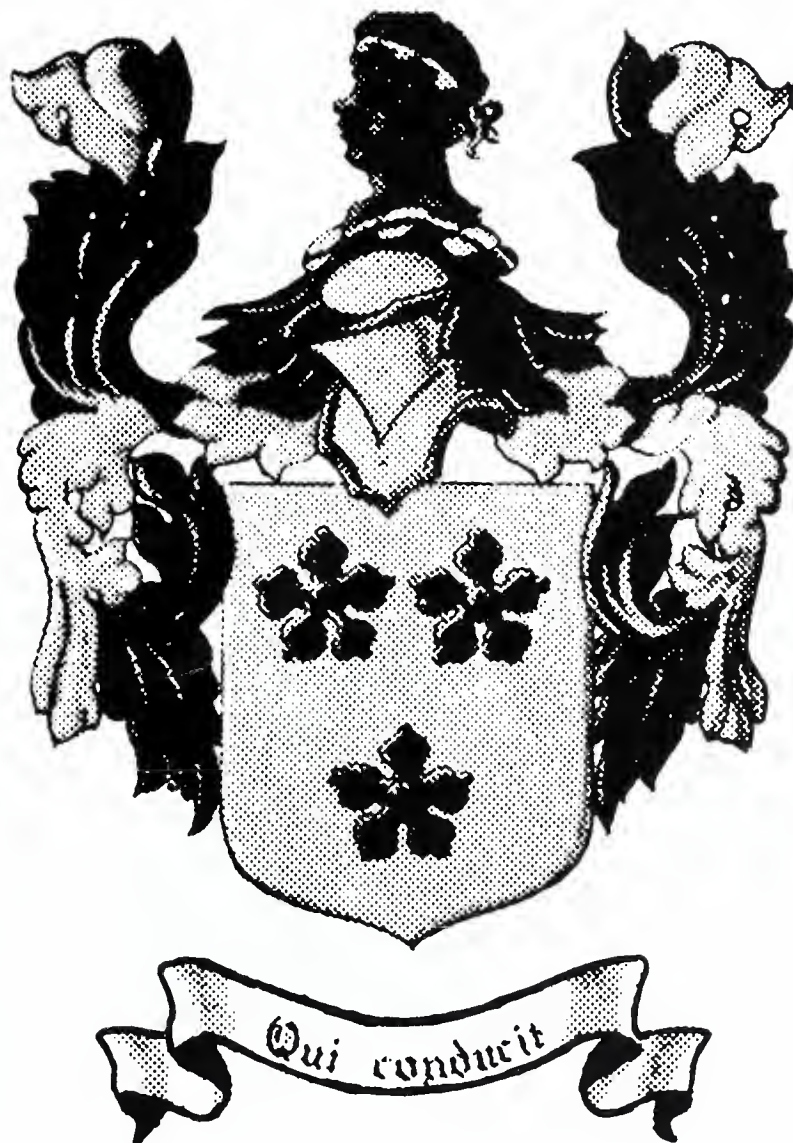
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The Role of the Detail Man

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

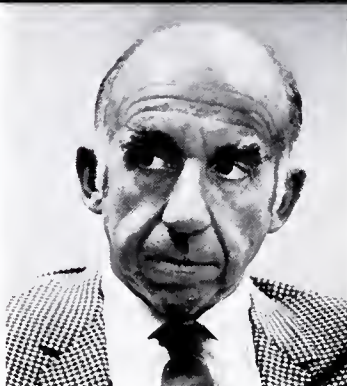
Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.

Dr. Willard Gobbell
Family Physician
Encino, California



Dr. Jeremiah Stamler
Chairman
Department of Community
Health and Preventive
Medicine, and Dingman
Professor of Cardiology
Northwestern University
Medical School



"In the total picture of dealing with health problems in this country, there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihood on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be — and at times actually are — disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets — some of it scientifically sound and therefore truly useful — as well as some excellent films produced by the pharmaceutical industry. When they function in this

He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. I go without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility

of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone

in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and

thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—i.e., the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that informa-

tion must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical
Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005



You know why there were no Aggie sailors on the Pueblo? Because it was an intelligence ship (Claude Caver's contribution)

Male contraceptive: Pebble in his shoe... Makes him limp (Contributed by **Betty Anderson**)

Pollyann just had her 6th child... Zeke asked Doc Jones: "Hey Doc... How do we stop having any more?" Doc Jones told him to go down to the corner drug store and purchase a condom. When Zeke returned, Doc Jones instructed him carefully: "Next time you have sex, put this condom on your organ..." Nine months later, Pollyann was ready to deliver again. Doc Jones turned to Zeke: "Did you put the condom on your organ like I told you to?" "Not exactly, Doc... You see we don't have an organ so I put it on our piano..." (As told by Sid Hashimoto, our lawyer friend)

The Woman's Corner...

The Woman's Auxiliary to the Honolulu County Medical Society elected **Bernie Yim** president, **Martha Kim** president elect, **Carol McNamee**, vice president, **Sharon Morton** recording secretary, **Sandra Shim** corresponding secretary, **Jane Uemura**, treasurer, **Carol Sunahara** and **Joan Young** members at large.

Doctors In Print

Hilo urologist **Manas K Ghosh** and Mayo Clinic Professor of Urology **L.F. Greene** have an article entitled, "Transurethral Resection of the Prostate in Patients with Myasthenia Gravis" in the Aug '74 issue of the *Journal of Urology*.

Physicians Speak Up

Mike Okihiro, Straub neurologist and football doctor for Castle High and Pac Five wrote a thought-provoking letter to Jim Easterwood re the KITV program "Danger in Sports: Paying the Price". Mike wrote: "To those football coaches, players and fans who think that Buster's broken neck and Vidal Velasco's subdural hematoma last football season were freak accidents, I would like to refer them to Dr Richard Schneider's recent book on 'Head and Neck Injuries in Football.'... The most important point I would like to emphasize is that as the game is being played right now, the potential for many more serious football injuries to occur is great... Unless some changes are made, we will be seeing more Busters and their broken necks... Sometimes it takes an aroused public to make changes come about... There are many ways to make this game a safer and a better game..."

The City Charter revision created a City Neighborhood Commission which in turn created neighborhood boards... Civic-minded **Fred Reppun** feels that neighborhood plan "establishes a legal mechanism whereby citizens will be spinning their wheels endlessly in order to be bringing recommendations to the councils of government. Nothing contained in the plan guarantees that government, at any level, need to do anything in response to their hard work on the part of citizens..." Fred also feels that these neighborhood boards may undermine voluntary community associations which are effectively mobilizing public opinion when the occasion arises...

Donald Char, in a letter to the editor, commended "Judge Herman Lum's talk to the Rotarians on the need for us to focus our attention on our young offenders if we are to cope with the ever growing problems of crime in America... He points out that 'what is needed is a system that reaches out to those youngsters early in their lives, long

before their appearance in court, when treatment can be helpful!... As a pediatrician, I could point out that treatment for these individuals is never very satisfactory, no matter when you apprehend them as problems! We must put more of our energies and resources into prevention... We must devote more attention toward supporting and assisting our American family. We need to restore a sense of personal responsibility within families for their own. We must insure that parents become effective in their roles as mothers and fathers, that elder members of the family and community develop meaningful relationships with each other as well as with children. This will teach our children more about being decent, loving, good human beings than any program of social helping that society can purchase... I submit that it is high time we looked at the root sources of our social problems, and hope that Judge Lum's comments will be circulated widely to insure greater community dialogue and action."

At a recent 4-hour forum on Maui's health issues with members of the Legislature's Health Committee, **Sakae Uehara** complained that current policies on health "sometimes amount to sledgehammer techniques for flyswatter problems." He cited a need for more personnel and said better programs must be worked out to provide maximum health care.

William Busse of Kailua got his dander up when an editorial referred very remotely "to consider the use of force" to obtain crude oil... "How soon we forget! Historically and economically, what prompted 'The Day of Infamy'? Shall the Arabs remember our attack for survival as another 'day of infamy' or is it possible that we could mature to the point where we may be able to negotiate with the 'inscrutable' Middle Eastern mind to arrive at a sensible and adult solution which is mutually acceptable in this crisis, without our world's children having to be wounded, maimed, and killed for our adult ineptitude and shortsightedness?"

Conference Notes

Roger Ogata spoke on rheumatoid arthritis at a Queen's Friday morning medical conference and we made the following notes:

"We don't say rheumatoid arthritis in the early stages... We say polyarthritis or polyarthralgia... Aspirate the synovial fluid to make sure it is not infectious arthritis, esp Tbc... Treatment of early RA is ASA... If the patient is allergic to ASA, then a trial of Metrin (Upjohn) or Naproxen (Syntex)... In mid-stage RA, there is synovial thickening of the joint capsule... Treat with corticosteroid injections, or gold... ASA may be too late. Splint and instruct in range of motion exercises... Manipulation may cause aggravation... For example with subluxation of the thumb, the worst thing is pushing those buttons on doors... In late-stage RA, there is a large amount of synovial tissue... Treatment is synovectomy, corticosteroid injections, and Cytoxan and Imuran... In gold reactions, there is a decrease in platelets... 80% mortality with thrombocytopenia from gold... Four years ago, a patient with severe thrombocytopenia was treated with BAL and steroids... "I think we scared the hell out of her arthritis, because she has recovered fully..."... A Surgeon General's office poster asks: "If the crippling of rheumatoid arthritis can be prevented in 7 out of 10 cases, why isn't it?"... Acupuncture is effective in osteoarthritis, but never for RA..."

Fellow rheumatologist Melvin Levin spoke at yet another Queen's conference on Reiter's syndrome, which he says is no longer a triad (ie arthritis, urethritis, conjunctivitis), but a sextad (with the addition of mucocutaneous and sacroiliac involvement and balanitis). **Harry Arnold Jr** added, "I'm a lumper... I hold that Reiter's and psoriasis are identical..." Jim Orbison commented: "Sexual activity parallels the incidence of Reiter's..." (From Doris Jasinski's notes) ■

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Both often



Predominant
psychoneurotic
anxiety

Associated
depressive
symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor

neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive dis-

orders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent

in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



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in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of child-bearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

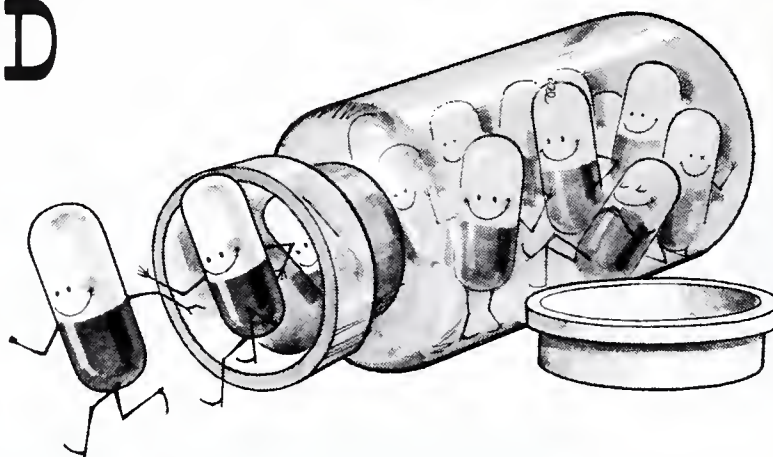
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle

spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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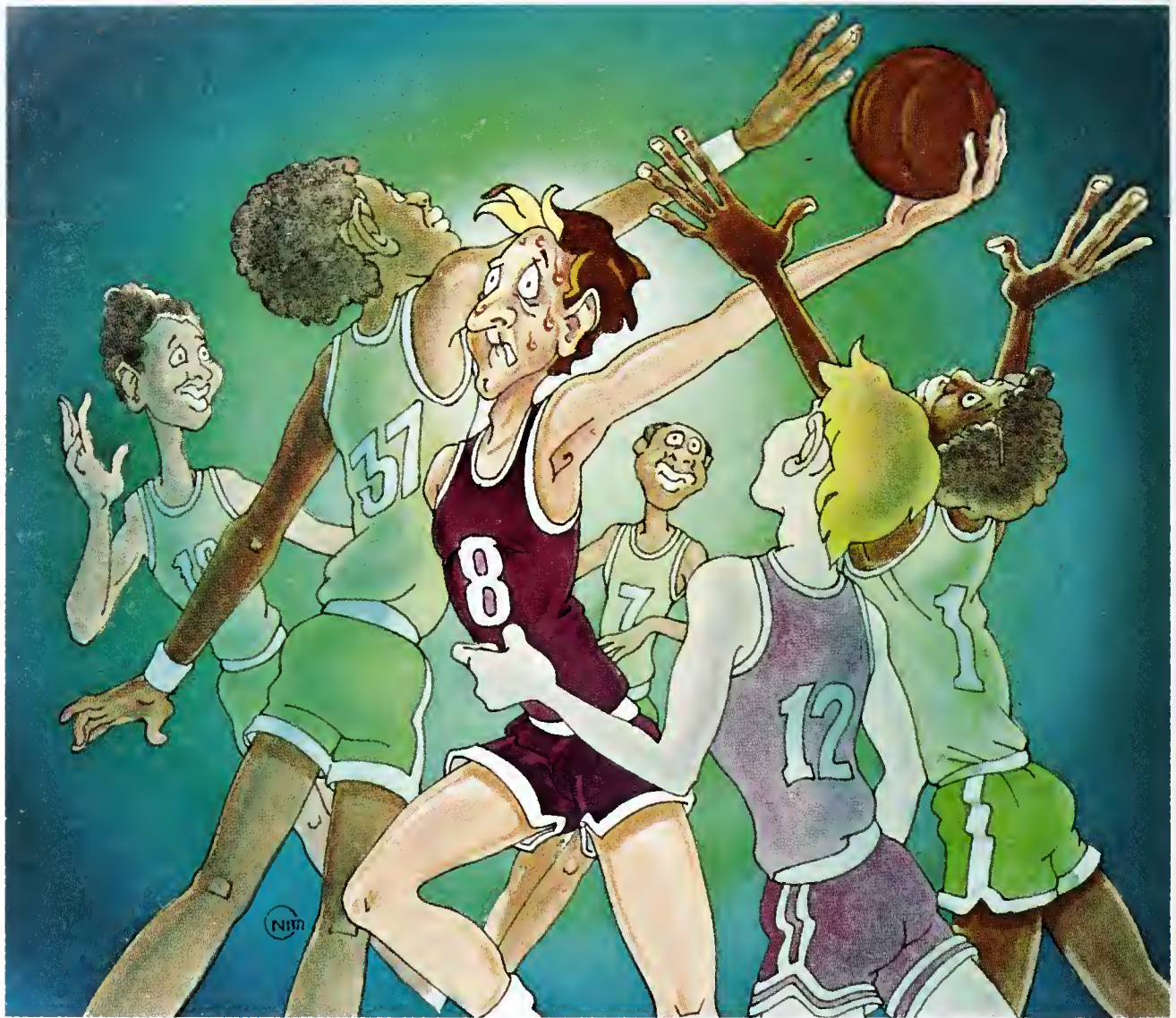
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(Warning: May be habit forming)
atropine sulfate 0.025 mg.

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IMPORTANT INFORMATION: This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: Lomotil is contraindicated in children less than 2 years old. Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of 1/2 ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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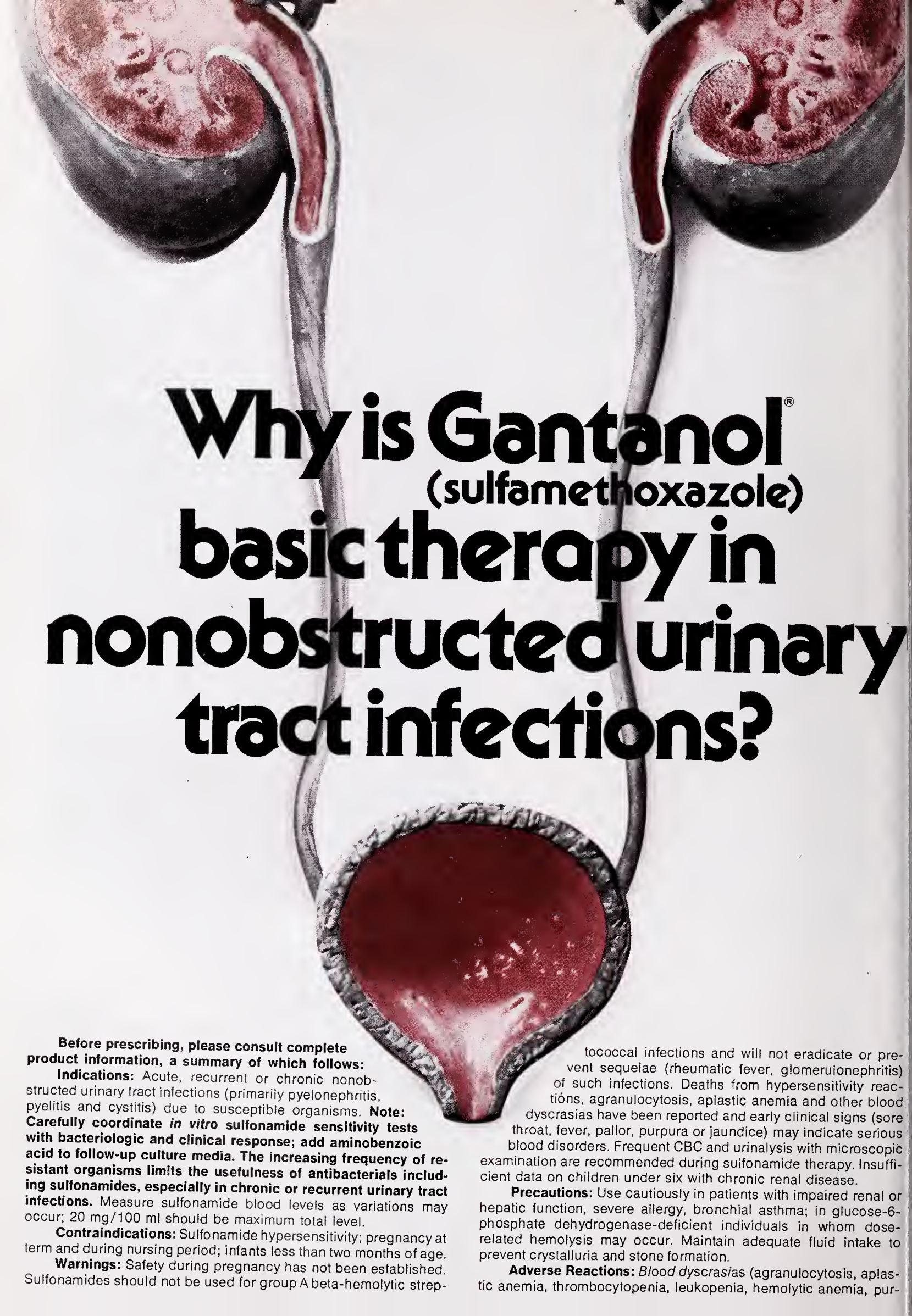
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Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic strep-

tococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: Blood dyscrasias (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, pur-

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pura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm b.i.d. or t.i.d. depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs b.i.d. Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.



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Early therapy for control of grand mal, focal and psychomotor epilepsy. Used alone or as concomitant therapy, MYSOLINE may reduce the frequency and severity of major

motor seizures—or even eliminate them. Based on years of clinical success, MYSOLINE has earned the reputation of being an *excellent* drug for control of grand mal epilepsy.²⁻⁴ But its usefulness is not confined to this type alone: MYSOLINE has proved to be valuable for control of psychomotor and focal epilepsy⁵ as well.

Improves response to concomitant therapy. When other anticonvulsants prove to be inadequate, adding MYSOLINE to the regimen can improve seizure control in grand mal and p



motor epilepsy. A double-blind comparative study⁶ shows that the combined use of phenobarbital, diphenylhydantoin, and MYSOLINE may have additive anticonvulsant effects without additive side effects.

Effective changeover therapy. Unsatisfactory performance or important side effects may force discontinuation of the patient's existing anticonvulsant therapy. For more effective control, MYSOLINE may be added to the patient's present regimen, then gradually substituted for the original medication. The changeover to MYSOLINE is frequently warranted when grand mal is refractory to phenobarbital, with or without diphenylhydantoin.⁷

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BRIEF SUMMARY

(For full prescribing information, see package circular.)

MYSOLINE® Brand of **PRIMIDONE**
Anticonvulsant

INDICATIONS: MYSOLINE, either alone or in combination, is indicated in the control of grand mal, psychomotor, and focal epileptic seizures. It may control grand mal seizures refractory to other anticonvulsant therapy.

PRECAUTIONS: The total daily dosage should not exceed 2 Gm. Since MYSOLINE therapy generally extends over prolonged periods, a complete blood count and a sequential multiple analysis-12 (SMA-12) test should be made every six months.

Use in pregnancy: The effect of primidone on the human fetus has not been studied, and the benefit of administration of any drug during pregnancy must be weighed against any possible effect on the fetus.

Neonatal hemorrhage, with a coagulation defect resembling vitamin K deficiency, has been described in newborns whose mothers were taking MYSOLINE and other anticonvulsants. Pregnant women under anticonvulsant therapy should receive prophylactic vitamin K₁ therapy for one month prior to, and during, delivery.

In nursing mothers: There is evidence that in mothers treated with MYSOLINE, the drug appears in the milk in substantial quantities. Since tests for the presence of primidone in biological fluids are too complex to be carried out in the average clinical laboratory, it is suggested that the presence of undue somnolence and drowsiness in nursing newborns of MYSOLINE-treated mothers be taken as an indication that nursing should be discontinued.

ADVERSE REACTIONS: The most frequently occurring early side effects are ataxia and vertigo. These tend to disappear with continued therapy, or with reduction of initial dosage. Occasionally, the following have been reported: nausea, anorexia, vomiting, fatigue, hyperirritability, emotional disturbances, diplopia, nystagmus, drowsiness, and morbilliform skin eruptions. On rare occasion, persistent or severe side effects may necessitate with-

drawal of the drug. Megaloblastic anemia may occur as a rare idiosyncrasy to MYSOLINE (primidone) and to other anticonvulsants. The anemia responds to folic acid, 15 mg. daily, without necessity of discontinuing medication.

DOSAGE AND ADMINISTRATION: The average adult dose is 0.75 to 1.5 Gm. per day. The initial dose is 250 mg. Increments of 250 mg. are added, usually at weekly intervals, to tolerance, or therapeutic effectiveness, up to daily doses not exceeding 2.0 Gm. A typical dosage schedule for the introduction of MYSOLINE is as follows:

Adults and Children Over 8 Years of Age

<i>1st Week</i> 250 mg. daily at bedtime	<i>2nd Week</i> 250 mg. b.i.d.
<i>3rd Week</i> 250 mg. t.i.d.	<i>4th Week</i> 250 mg. q.i.d.

In children under 8 years of age, maintenance levels are established by a similar schedule, but at one-half the adult dosage. It is best to begin with 125 mg., with gradual weekly increases of 125 mg. a day, to a daily total usually between 500 mg. and 750 mg.

In patients already receiving other anticonvulsants: MYSOLINE should be gradually increased as dosage of the other drug(s) is maintained or gradually decreased. This regimen should be continued until satisfactory dosage level is achieved for combination, or the other medication is completely withdrawn. When therapy with this product alone is the objective, the transition should not be completed in less than two weeks.

MYSOLINE 50 mg. Tablet can be used to practical advantage when small fractional adjustments (upward or downward) may be required, as in the following circumstances: for initiation of combination therapy; during "transfer" therapy; for added protection in periods of stress or stressful situations that are likely to precipitate seizures (menstruation, allergic episodes, holidays, etc.).

HOW SUPPLIED: MYSOLINE Tablets—No. 430—Each tablet contains 250 mg. of primidone (scored), in bottles of 100 and 1,000. Also in unit dose package of 100. No. 431—Each tablet contains 50 mg. of primidone (scored), in bottles of 100 and 500. MYSOLINE Suspension—No. 3850—Each 5 cc. (teaspoonful) contains 250 mg. of primidone, in bottles of 8 fluidounces.

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Bromelain As A Skin Cancer Preventive In Hairless Mice

NORMAN GOLDSTEIN, M.D.*, STEVEN J. TAUSSIG, Ph.D.**,
JAMES D. GALLUP, M.D.+, and VERNON KOTO++, *Honolulu.*

●*The use of proteolytic enzymes in cancer therapy is not new. In 1906, Beard¹ first suggested the use of pancreatic enzymes. Since then, many papers have appeared on the use of enzymes of plants, animals or bacterial origin for cancer therapy². A review paper on bromelain is to be published shortly by Taussig and Yokoyama³.*

Recent reports⁴ on the oral administration of 600 mg/day of bromelain describe complete disappearance of cancerous masses in a breast cancer and a fibrous transformation of cutaneous metastasis. In both cases, bromelain had been used as the sole therapeutic agent. Both Gerard and Nieper⁵ have shown that the use of bromelain in conjunction with conventional cancer therapy results in a statistically significant improvement in overall survival, as well as in reduction or disappearance of tumors.

The skin provides an easily accessible means of evaluating therapeutic and possible prophylactic modalities in cancer research. Cutaneous neoplasms can easily be observed, photographed and biopsied in patient and laboratory animal. Skin cancers may be induced in hairless mice by repeated exposures to ultraviolet light. Using carcinogens such as DMBA (dimethylbenzanthracene), J. Epstein⁶ produced cancers within three to four months after starting ultraviolet treatments. Forbes and Urbach⁷, using

banks of fluorescent sun lamps, produced tumors without the use of carcinogenic agents, though the tumors developed much more slowly. Goldstein and Murakami⁸ then demonstrated that these light-induced tumors may be prevented by the application of a PABA in alcohol sunscreen prior to the ultraviolet light exposure.

In this study, food grade bromelain, a proteolytic enzyme extracted from the stem of the pineapple⁹ was evaluated as a skin cancer preventive. This substance is by no means a chemically homogeneous product. Bromelain is a glycoprotein having proteolytic, peroxidase and acid phosphatase, as well as other enzymatic activities.

Materials

1) *Mice*—Hairless mice, a genetic species of bald mice, were obtained from the Jackson Laboratories, Bar Harbor, Maine. They were housed, five mice in a cage.

2) *Light Source*—Westinghouse fluorescent sun lamps (FS40W) were installed in a specially constructed light box. The skin-light distance was 381 cm (15 inches). Control animals were exposed only to incidental laboratory lights (standard "daylight", fluorescent ceiling mounted bulbs).

3) *Feed and Water*—Animals were permitted water ad lib. Control animals were fed ground Purina Standard Lab Chow. Test animals were fed a special bromelain enriched chow containing 0.04% bromelain. This amount is approximately equivalent to 2 mg bromelain/mouse/day or 80 mg bromelain/Kg of body weight/day. The bromelain was prepared by the Foods Divisions of Castle and Cooke Inc., Honolulu,

From the Photobiology Research Laboratory, the Queen's Medical Center, Honolulu, Hawaii 96813.

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**Chemical Consultants, International

+Chief, Pathology Department, The Honolulu Medical Group

++Premedical Student, University of Hawaii

Accepted for publication Jan. 22, 1975.

FIG. 1.—Plastic feeding tray



Hawaii. It is standardized to 1200 GDU (gelatin digestion units). A plastic feeding tray was designed to reduce scattering of the chow (Figure 1).

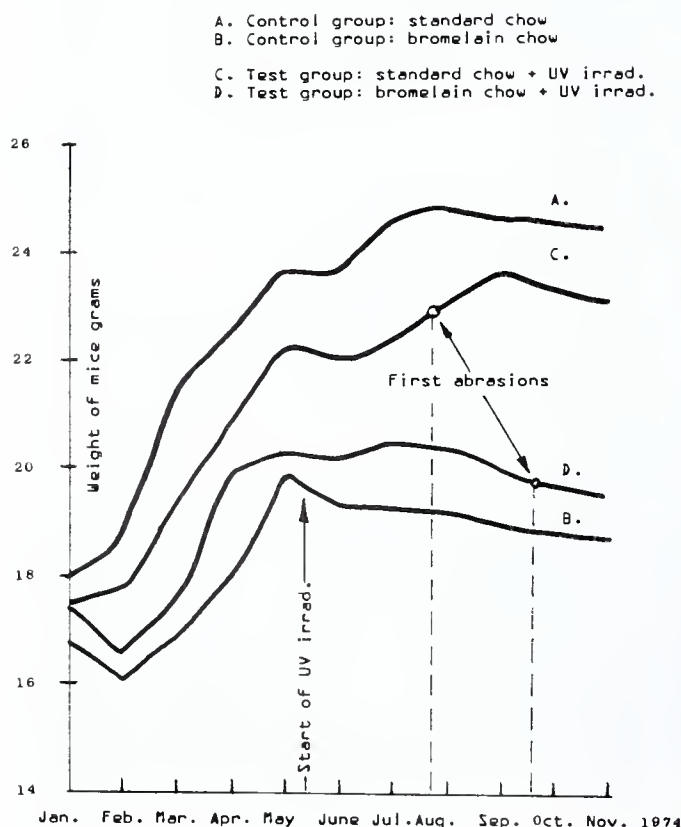
Method

Four groups of mice, each containing 10 mice, were studied as indicated:

- Control—standard chow—no ultraviolet light.
- Control—bromelain chow—no ultraviolet light.
- Test—standard chow—ultraviolet light three times weekly.
- Test—bromelain chow—ultraviolet light three times weekly.

The study began in January, 1974. Initially, the hairless mice did not ingest the chow with the concentration of bromelain employed in

FIG. 2.—Average weights of mice



earlier studies using standard mice. The optimum concentration of bromelain was determined empirically and this feed started on April 25, 1974. Amounts of feed ingested weekly were recorded, as were the weights of the animals (Figure 2).

Ultraviolet exposures were started one month later. Treated mice were exposed to 15 minutes of ultraviolet light three times weekly for six months. Visual observations were made at least three times weekly and photographs of erosions and tumors made at monthly intervals. Skin biopsies were obtained and examined histologically.

Observations

Bromelain-fed mice lost weight until an improved feeding device and optimum diet was determined. Two months after ultraviolet exposures had begun, superficial abrasions were noted on the backs of mice in Group C but not in the bromelain-fed UV exposed, or control groups.

One mouse died in each control group (A & B), one in C and two in Group D. The mouse in Group C had a lymphoma, unrelated to bromelain, light therapy or skin cancer. One mouse in Group D, who died September 7, 1974, was found to have an acute and chronic inflammation of the salivary gland. The cause of death of the other mouse in Group D and the two con-

FIG. 3.—Group A-1 control, regular chow, no ultraviolet light



FIG. 4.—Group B-1 control, bromelain chow, no ultraviolet light



FIG. 5.—Group C-1 test group, regular chow, ultraviolet light 3x weekly for six months. (Precancerous changes noted in 7 biopsies, and acute and chronic inflammation in 2 biopsies).



FIG. 6.—Group D-1, test group, bromelain chow, UV light 3x weekly for six months (a: verrucoid papule, b & c: acute and chronic epidermal erosion with fibroblastic proliferation. No evidence of cancerous or precancerous changes).

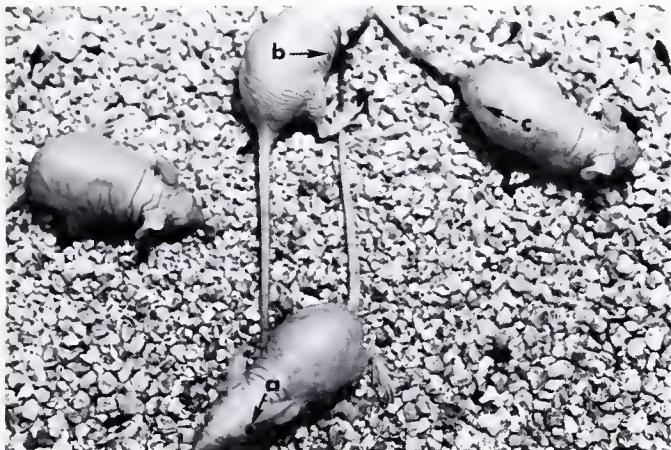
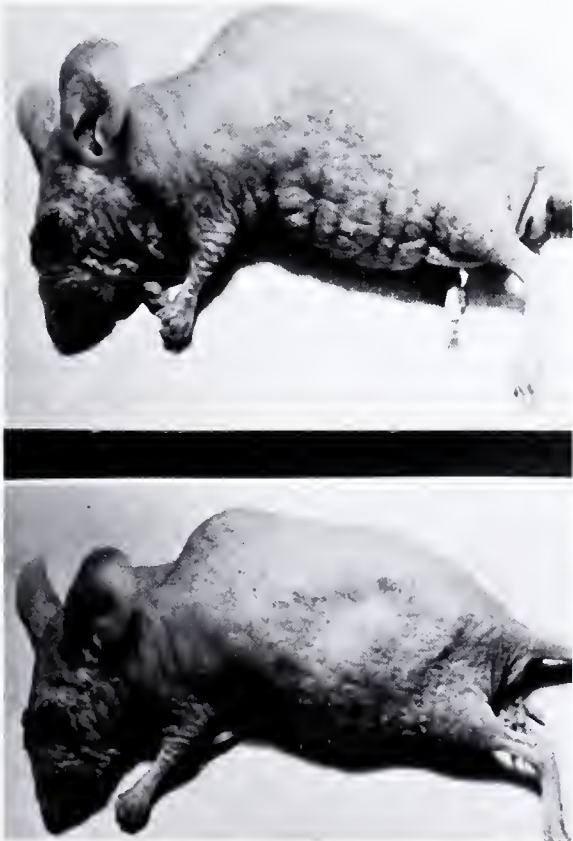


FIG. 7.—A & B Close-up photographs. Group A (Top) & B (Bottom) mice (controls).



trol mice could not be determined by autopsies.

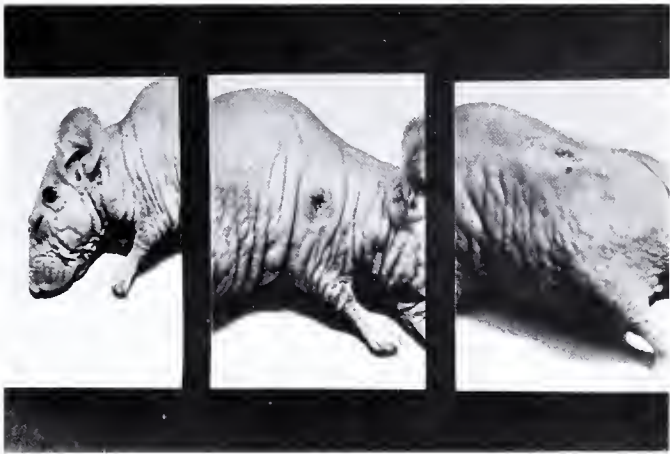
Photographs (Figures 3-6) of the four groups were obtained, and representative biopsies were taken from the mice in each group on November 6, 1974, approximately 5 1/2 months after UV exposures were started. Two mice in each of the control groups demonstrated "normal skin and connective tissue" (Figures 7A and 7B). A total of 9 biopsies were obtained from Group C (regular chow). Seven lesions were interpreted as precancerous changes, and two demonstrated acute and chronic inflammation (Figure 8).

FIG. 8.—Close-up photographs of mice in Group C. Precancerous and inflammatory changes noted histologically.



Group D (the bromelain-fed, ultraviolet-light-exposed mice) had very few lesions (Figure 9).

FIG. 9.—Close-up of mice in Group D. Verrucoid papillomas and inflammation with erosions noted histologically.



One was a verrucoid papule on the side of the head (a). Two other mice each had a solitary firm nodule (b & c) with depressed centers, suggestive of basal cell cancer. Pathologic examination, however, revealed "acute and chronic epidermal erosions with fibroblastic proliferation" with no evidence of cancerous or precancerous changes.

Conclusions

It appears that the ingestion of bromelain in feed by hairless mice has in some way reduced the number of precancerous lesions. Obviously, the inference cannot be made at this time that ingestion of bromelain will reduce or prevent

skin cancer in human subjects. The results are sufficiently encouraging, however, to show that further studies are now indicated.

Acknowledgments

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Psychological testing to identify brain damage . . .

Cross-Validation Of The Halstead-Reitan Neuropsychological Battery: Application In Hawaii

JEROME I. BOYAR, Ph.D., and
WILLIAM T. TSUSHIMA, Ph.D.,* *Honolulu*

●*The usefulness of the Halstead-Reitan Neuropsychological Test Battery has been documented by a substantial bibliography of research and clinical papers (Russell, Neuringer, & Goldstein, 1970).¹ For over 20 years, Ward Halstead (1947)² at the University of Chicago conducted a long-term investigation of a battery of tests specifically developed to measure the effects of brain pathology. Subsequently, one of Halstead's students, Ralph Reitan (1966),³ examined well over 2,000 patients with documented brain lesions at the Indiana University Medical Center, producing evidence for extensive cross-validation.*

Vega and Parsons (1967),⁴ at the University of Oklahoma Medical Center, argued that many psychological tests are unable to withstand the test of cross-validation over different geographic regions and socioeconomic classes, due to the lack of adequate normative data. Testing the validity of the Halstead-Reitan battery, they found that the subtests of the neuropsychological test battery clearly differentiated a group of brain-damaged patients from a group of control subjects. The authors noted that cultural factors accounted for a relatively lower level of performance among the Oklahoma subjects, compared to the Midwest sample of patients examined by Reitan, but they found that the correct identification of brain impairment remained at a respectable 73% accuracy.

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The Halstead-Reitan battery has been applied successfully in various areas of the country—West Coast, Wisconsin, Kansas and Vermont. Several neuropsychologists in Canada have also realized the utility of this test battery.

Nevertheless, there remains a significant gap in the normative data of the Halstead-Reitan battery, with an absence of data collected from individuals varying in age, education, and socio-cultural background. The Halstead-Reitan battery in no way compares with the Stanford-Binet or the Wechsler scales, with regard to standardization on representative samples from the general population.

Because of the lack of published normative data, this paper was developed as a means to demonstrate the usefulness of the Halstead-Reitan battery in Hawaii. This study also aimed to demonstrate that this test battery could be administered in a clinical setting involving reasonable time and patient-cost; virtually all of the studies cited above were done in major research centers.

Method

Test Materials. The tests under investigation, viz., the Halstead-Reitan Neuropsychological Battery, included the following: the Category Test, the Tactual Performance Test, Seashore Rhythm Test, Speech-sounds Perception Test, Finger Tapping Speed Test, Trailmaking Test, and the Aphasia Screening Test.

In addition, the Wechsler Adult Intelligence Scale, the Wechsler Memory Scale, Purdue Peg-board, Dynamometer, Wide Range Achievement Test (Reading), and the Minnesota Multiphasic Personality Inventory were also given.

The tests were administered and scored by a psychology technician under the supervision of a clinical psychologist, who interpreted the test results.

Subjects

The 120 subjects for this study were patients, all of whom received a neurological examination, including an EEG and skull x-rays, in a private medical group setting. They were divided into three groups of 40 patients each.

A “normal” group of 40 subject were patients who presented symptoms possibly caused by neurological disorder, but who were found to be without pathology by a neurologist or neurosurgeon. There were two groups of “brain damaged” subjects. One group of 40 patients (to be called “neurological” patients in this study) consisted of those found to have brain impairment on the basis of a neurological examination, EEG, and skull x-rays only. A second “brain damaged” group of 40 patients (to be called “neurosurgical” patients in this study) consisted of those found to

have brain impairment on the basis of neurological examination, EEG, and skull x-rays and, in addition, to have more definitive pathological findings, as reported from surgery, brain scans, pneumoencephalograms, angiograms, or autopsy. The 80 “brain damaged” patients carried various diagnoses, including head trauma, convulsive disorder, cerebrovascular disorder, degenerative disease, or tumor.

The mean age of the patients in this study was 41, and the mean educational level was 13.5 years. Compared to previous investigations, such as those of Reitan and Vega and Parsons, this study investigated patients of similar age but of somewhat higher educational level.

The racial-cultural makeup of the patients in this study was typical of clinical practice in Hawaii, with patients of European, Chinese, Japanese, Korean, Filipino, Hawaiian, “other” polynesian, and finally “cosmopolitan” (multiple-mixed) backgrounds.

Results

IDENTIFICATION OF BRAIN IMPAIRMENT

Table 1 reveals the relationships between the findings of neurological and neurosurgical examinations and of neuropsychological testing.

TABLE 1.—Comparison of Neurological-Neurosurgical and Neuropsychological Examination of Impaired and Normal Patients.

	NEUROLOGICALLY IMPAIRED		NEURO- LOGICALLY NORMAL
	<i>Neurological Patients</i>	<i>Neuro- surgical Patients</i>	
Neuropsychologically Impaired	33	40	15
Neuropsychologically Normal	7	0	25
% agreement	83%	100%	63%
	Overall Agreement		82%

As can be seen, among the neurological patients, 33 patients or 83% were also found to be impaired neuropsychologically. Of the neurosurgical patients, 100% were found to be impaired on the Halstead-Reitan Tests. Normal patients presented more discrepant data, as 15 patients or 37% of those found to be “normal” neurologically were found to be “brain damaged” on the neuropsychological tests.

The overall agreement between the neurological-neurosurgical examinations and the neuropsychological methods in identifying cerebral impairments among the 120 subjects was 82%. This accuracy rate compares favorably with the 73% correct classification of brain-damaged subjects in the Vega and Parsons study, and with the 75% correlation reported by Goldstein and his

associates at the University of Vermont in 1973.

LATERALIZATION OF BRAIN LESIONS

Lateralization of brain lesions has been a major focus of Reitan's work in recent years. Varied studies have demonstrated that the Halstead-Reitan tests can predict to a high degree right or left or bilateral hemispheric involvement.

Among the 40 neurological patients, 19 had bilateral cerebral hemisphere involvement, 13 primarily left hemisphere impairment, and eight had right hemisphere impairment. With these patients, the neuropsychological lateralization test results agreed with the neurological findings on 22 patients, an agreement rate of 58%.

The 40 neurosurgical patients evaluated were classified as follows: 19 both hemispheres, 12 left hemisphere, and nine right hemisphere. The neuropsychological lateralization test results agreed with the neurosurgical findings in 87% of the patients.

Thus, among the 80 patients diagnosed as "brain-damaged" in this study, there was an overall agreement of 73% between the neurological-neurosurgical results and the Halstead-Reitan tests with regard to the lateralization of brain lesions. This figure can be compared with the work of Russell and his associates in Topeka, with a 78.5% agreement for lateralization¹ and the results of Filskov and Goldstein, at the University of Vermont, with 89% agreement for lateralization.⁵

Discussion

The overall results of this study firmly establish the Halstead-Reitan Test Battery as an effective neurodiagnostic technique for the assessment of cortical cerebral dysfunction among patients in Hawaii.

While previous studies of the Halstead-Reitan battery were conducted in major research centers, this study demonstrated that the test battery can be utilized effectively in a clinical setting, administered by a technician, involving reasonable time and patient cost. The results, thus, argue for the inclusion of this test battery in diagnostic workups, along with the more traditional neurodiagnostic tools. It has the advantage of being as benign a procedure as a skull x-ray or brain scan. The fact that the tests are based upon quantitative evaluation of function rather than direct physiological measurement is not a relevant issue, despite the tendency to view physiological measurements as automatically superior to functional ones.

With the neurological patients, the agreement between the neurological findings and of neuropsychological test results is substantial, though not as high as with the neurosurgical patients. There are at least two possibilities to explain this finding: (1) among the neurological patients, the nature of the pathology was simply less clear and less severe than among the neurosurgical patients and, therefore, less susceptible to definitive agreement with the neuropsychological test data; (2) the neurological exam with EEG and skull films is less exact than the pneumoencephalogram, angiogram, and surgical information. The 100% and 87% agreements between the neuropsychological results and the neurosurgical data are a function of the precision of the diagnostic methods used with the neurosurgical patients, and also a function of the nature of their more serious illness.

The comparative accuracy of the neurological-neurosurgical evaluations and the Halstead-Reitan battery has been assessed by a recent study (Filskov & Goldstein, 1974),⁵ which found the Reitan battery to be as accurate as the pneumoencephalogram and the arteriogram, and superior to the EEG, skull x-ray, and brain scan. In view of these results, it appears that much can be gained by including the Reitan battery as a more frequent part of neurological evaluation.

Conclusions

The Halstead-Reitan Neuropsychological Battery was used to evaluate 120 patients, in three groups (normal, neurological, and neurosurgical) of 40 patients each, in a private medical clinic in Hawaii. An extremely high degree of concordance between neuropsychological results and neurodiagnostic data was found in patients undergoing neurosurgical evaluation, with a less high but still substantial concordance in patients undergoing routine neurological exam. The study demonstrated clearly the utility of the Halstead-Reitan battery in Hawaii, with accurate results, regardless of a broad range of educational, racial and sociocultural backgrounds in patients tested.

Acknowledgments

This study was made possible by a grant from the Queen's Medical Center, Honolulu, Hawaii. The authors would like to extend very special thanks to Mrs. Edna Casem, whose work upon this project was absolutely vital.

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Killing the Goose that laid the Golden Egg . . .

How did we get into this mess, anyway?!

Malpractice, such a popular term these days—if not a popular concept—was hardly, if ever, discussed by our medical grandfathers—yet it is about to ruin medical practice in this country, and hence to endanger care of the sick and wounded.

They are about to kill the goose that laid the golden egg, are those tort lawyers; those few patients and their families who have made a career out of a lawsuit, and those juries which have granted such huge awards that insurance companies no longer wish to gamble by insuring physicians and surgeons, upon whose skill health and sometimes life itself depends.

Most physicians will never be sued. It is indeed gratifying to mull over this thought. The current figures are that approximately one out of three MD's will be sued for malpractice. That means that 66 per cent of us will not ever be sued, if current trends continue.

But who wants to play that kind of Russian roulette? . . . So, scared, we *all* rush out to buy malpractice insurance at exorbitant rates. We are forced to behave as if each of us were going to be sued, and more than once!

Of course, there is always a chance that current trends may change. The new trend might be that 90 per cent of us could expect to be sued! There might even be an open season on doctors!

It might even become a popular new indoor sport—sue the doctor. Instead of exchanging notes on each other's operation, matrons might exchange notes on the lawsuits pertaining to their operations!

Because a few patients will find grounds for suit against a few doctors, all doctors are forced to buy excessive insurance and to pay excessive rates—rates so high in some cases that apparently competent and skilled surgeons are forced out of practice. \$44,000 a year for insurance for each orthopedic surgeon in New York would be ridiculous if it weren't so altogether sad!

None of us went to medical school to study how to avoid lawsuits (though the subject *did* come up). We went to medical school for positive reasons: to learn to heal the sick, alleviate suffering, comfort the anguished, and to repair the injured and the maimed. Now it is we who are maimed and who require comforting!

When casting about for who or what to blame for the present malpractice pickle, sometimes the personal injury or tort system that is current in this country's courts is held to be at fault.

But perhaps the problem has arisen because all of us have malpractice insurance—no right-thinking doctor would be without it! Even those of us who rarely wield a scalpel, never use a saw and hardly ever "pass gas".

What if—just supposing what if we didn't have insurance against being sued?

Everyone knows that all doctors have malpractice insurance and therefore can "afford" to be sued.

But what if all we had were the mortgages on our home and car, and a pile of bills—what could we be sued for? What could anyone hope to "recover"? No jury would take the roof from over the heads of the doctor's family—or would it?

Representatives of the legal profession say doctors should not have "immunity from fault"—that is, doctors should be suable for any acts they perform in the line of duty. Therefore, say the legal types, arbitration of malpractice should not be taken out of the courts.

Surely the tort lawyers have much at stake in this issue. It has been alleged that since no fault auto insurance ruined that fertile field for tort lawyers, they have had to earn their bread and butter in malpractice suits against physicians. Pity the poor tort lawyers!

Perhaps the real problem is that, in addition to there being "a shortage of doctors", there are just too many lawyers. They are falling over each other looking for work.

If tort lawyers are forced to make a living by driving medical practitioners out of practice, perhaps these lawyers should turn to a more humane means of livelihood!

Some of my best friends are lawyers, but how did we get into this mess, anyway?

DRJ

SN(i)F has us in a SNIT!

SNF is the acronym for Skilled Nursing Facility. Surely all physicians know that. But then again, maybe many of you avoid the SNF (the next level below "acute care,") by turning your nursing home patients over to someone else for follow-up.

ECF, or Extended Care Facility, is no longer in the Medicare/Medicaid lexicon, but ICF (Intermediate Care Facility) still is, and the long road continues, on to Nursing Home and Care Home. This descent into oblivion is the fate of most geriatric patients. Very few—mostly the younger ones—make it on an uphill track towards self-care and self-sufficiency. The further down the road the patient goes, the less interested in his/her welfare is DHEW.

Regional Long Term Care Letter No. 74-8, out of DHEW last September stipulates a new and astounding concept in the regulation of SNF's. Physicians and nurses in charge of patient care in these nursing facilities are no longer to be trusted with the choice and use of drugs and medication.

"The pharmacist **must** review the drug regimen of each patient at least monthly, and **must** report any irregularities to the medical director and administrator."

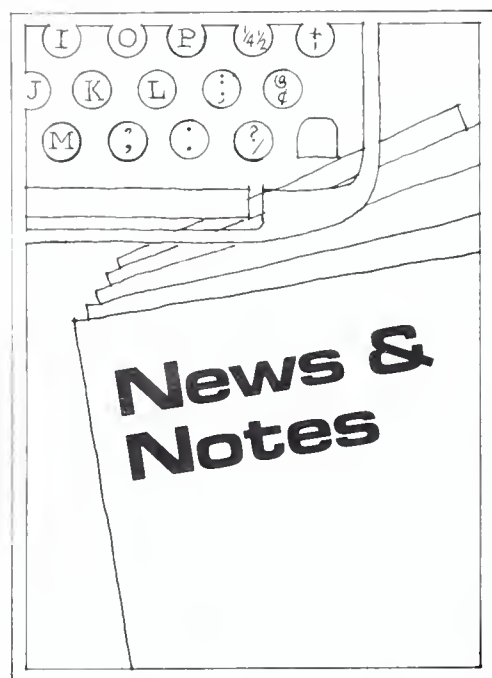
The "interpretation" of this regulation includes a mandate for the pharmacist—the superphysician, if you will—to review the chart, to "possess knowledge of the patient's condition," and to "interview the patient . . . in order to make a professional judgement . . ." The pharmacist has to document this review, and certify that he has done so, on each patient every month!

The regulation goes on to stipulate that a "surveyor" (shades of the CIA!) must then snoop on the pharmacist, and as a political Commissar, this surveyor must satisfy his superiors in Region IX that the poor benighted pharmacist has indeed found the alleged "irregularities"!

What a horrible position for the meek and mild pharmacist to find himself in!

Physicians and pharmacists all! Awake! Awake! Let us unite in order to drive this DHEW monster back into his Washingtonian lair!

JIFR



HENRY N. YOKOYAMA, M.D.

Life in These Parts

Our innovative HMA receptionist, **Sue Anzai** gave us these thought provoking slogans:

"Once a king, Always a king... But once a knight is enough."

"A Smile A Day... Keeps the Boss Thinking."

"I'm at the middle age of life... Too late for sex and too early for old age pension."

What's In A Name?

"It always seems appropriate that a Dr **Newbill** is on the staff of the Ear, Nose, and Throat department at Straub Clinic." (From *Honolulu Magazine* with our apologies to Dan)

Someone with a sense of humor looked through those registered at the recent Pan Pacific Surgical Conference and came up with the following list: "Dr Savage, Dr Payne, Dr Ill, Dr Crook, Dr Rob, Dr Skinner, Dr Smart, Dr Snook, Dr Speed, Dr Tardy, Dr Waite, Dr Goodfriend, Dr Worst and Dr Organ. And a Dr Foote is a colon specialist..." (From Tom Horton's Column)

Hospital Association director, "**Doc**" **Burkett** introduced his wife at a hospital seminar: "I call her Angel because she's usually up in the air about something, harps on my faults and hasn't a blessed thing to wear..." (Methinks we can all use such an introduction sometime...)

Legislators were dumbfounded when **David Holaday**, the Health Dept's chief of hospital and medical facilities branch testified that the Hawaii State Hospital operated illegally without a State license from 1968 to 1972, but David clarified that the lack of credentials was an administrative foul up rather than a result of hospital deficiencies...

In December, new state labor director **Joshua Agsalud** announced that workman's comp fees will go up Jan 1 and that the revised fee schedule can be obtained by calling the department's disability compensation division... (Well, it's about time... and after all that horrendous hassle...)

The National Heart and Lung Institute's seven-year Coronary Drug Project involving 55 research centers throughout the country announced that a study of 8,000 men showed that Clofibrate and Niacin, both widely used, were useless for prolonging life in post MI patients. Locally, the study was conducted by the Pacific Health Research Institute with **Bob Wiener**, **Fred Gilbert** and **A.S. Hartwell** and involved 150 post infarct men between ages 30 and 65...

Lung cancer patient Minnie Pagan, 55, who used Marijuana tea for pain relief and appetite enhancement died in February. Attending physician **Charles Hesterly** of Honokaa had testified that no known drug he could prescribe had the

same "positive" effect on her... Charges against her husband for possession of 52½ pounds of marijuana had been dropped...

In February, Kauai district health officer **Richard Cardines** reported 31 cases of infectious hepatitis among young residents of the Haena-Hanalei area "who were socializing together, sharing foods, beverages and cigarettes and also sharing hepatitis."

Our crusading rat killer, Maui's **Alice Broadhurst** reported in early Feb that 14 of 32 rats trapped in the Paia area were infected with typhus and urged residents to clean up their "rat breeding yards of junk and tall grass." Resentful Paia residents felt that the warnings about the rats "have been exaggerated by the newspapers." Alice reports that there had been 3 actual human cases of typhus in the past 3 years...

Tom Thorson's Corner

Zeb was gettin' nigh on 18 and still single. His pappy Silas sez, "Zeb, you're gettin' on in years... Time you got yourself a wife... Why don't you go a courtin' Mary Jane?" So Zeb does like his pappy sez and goes a courtin' Mary Jane. He returns a week later, and complains, "Can't marry her... I found out she's still a virgin..." Pappy Silas agrees, "Yep, if she ain't good 'nuff for her kin folk, she ain't good 'nuff for us..."

Three gals, Mary, Jane, and Sally, were discussing the men types they would prefer to marry... Jane says, "I want to marry a lawyer... Then I can get advice for nothing..." Sally: "I'll choose a doctor... Then I can be treated for nothing..." Mary was quite definite: "I'm going to marry a preacher... Then I can be good-for-nothing..."

Professional Moves

Unlike its fierce predecessor, the Tiger, the Year of the Hare has thus far acted rather timidly. Internist **Ronald Perry** opened his office at 2221 So. Beretania (formerly **Al Shimamura's** office) and GP **Charles Moss** opened at the Kaiser Clinic at 45-602 Kam Highway, Kaneohe. On Maui, GP **Donald Altfeld** joined the Maui Medical Group. (From the *Maui News*, we learned that Don is a songwriter with over 100 recorded and published songs to his credit, including the million selling "The Little Old Lady from Pasadena" and the Albert Hammond hit "It Never Rains in Southern California.")

Physicians Speak Up

The manslaughter conviction of Kenneth Edelin after a legal abortion at Boston City Hospital caused the following reactions:

HMA prexy **Wini Lee** took issue with the verdict: "This 20 to 24 week fetus, as reported in this particular case would not be considered viable even with the best of neonatal care. The medical judgment would therefore tend to be against the decision of manslaughter. Emotional factors may have played a large part in the decision by a lay jury."

Urologist **John Edwards**: "It's a paradox! How can a person perform a legal abortion and then get convicted for manslaughter. That doesn't make any sense at all. I don't think the case will change the abortion picture, unless Edelin doesn't win his appeal. It may, however, reestablish tougher abortion guidelines."

Ob-Gyn man **George Goto**: "I believe the decision will be reversed. He was convicted on emotional grounds. The case will make doctors more cautious about taking late abortion cases and women will come in earlier, rather than wait."

Family planner **Ron Pion**: "It's a big 'shibai' again. People say abortion is not the issue. In my reading, abortion is the issue. It's a fight by sincere people and Edelin is caught in the middle. As I understand the law, I would say the decision represents an induced miscarriage of justice..."

Sportsmen

In December, our perennial olympic official and girl watcher, **Richard You**, reported from an Orlando, Florida U.S. Olympic convention that a Fanne Foxe, known as the Tidal Basin Bombshell was the talk of the town. "She got busted for going bottomless right here where a bunch of clean-living olympic athletes and officials are planning for the 1976 Monneal Olympics..."

Also in December, chess enthusiast **Kenneth Haling** reported that the Maui Chess Club will hold a two day open chess tournament at the Maui Community College... In January, **B.A. Weeks** and partner placed 3rd in the East-West tournament of the Wailuku Bridge Club's annual membership game... On Feb. 15, cyclist **Dale Adams** placed 4th in a field of 71 riders who started the 77-mile race from Haleiwa Beach Park to the Waikiki Shell.

Elected, Appointed, & Honored

Our kudos to amiable **Larry Wong** who was recently elected Chief of Staff at St. Francis Hospital. **Al Chun-Hoon** was elected vice president, **Walter W.Y. Chang** secretary and **Ray Fujikami** treasurer. Others on the St. Francis Executive Board are **Livingston Wong**, Chief of Surgery; **H.H. Chun**, Chief of Medicine, **Francis Soon**, Chief of Gynecology; **Robert Ballard**, Chief of General Practice; past president **Francis Won** and members at large **Wini Lee**, **Bill Dang**, **L.Q. Pang**, **Carolina Wong** and **Herb Chinn**...

Audrey Mertz, Big Island health officer, was named deputy director of the State Health Department. Audrey is scheduled as a panelist at the 4th annual secretarial seminar of the Big Island Chapter of the national Secretaries Association International. The theme is "Today's Woman."

Andrew Sackett, former assistant surgeon general of the US Public Health Service and more recently, medical director of Hale Mohalu has been named chief of the Communicable Disease Division succeeding **Ira Hirschy** who retired Dec. 30. **Pat Aiu** was named a director of the Kauai Canoe Racing Association...

Locker Room Dialogue

The American Jew walks into a New York City Chinese restaurant and when the Chinese waiter comes for his order, asks: "Do you have any Chinese Jews?" The waiter, only recently from Hong Kong, looks bewildered, but regains his composure and says, "You wait... I ask cook." A flurry of Chinese dialogue reverberates from the kitchen... The waiter returns and reports: "Cook say we got orange juice, pineapple juice, apple juice, apricot juice, but no got Chinese juice..." (Heard by **Ben Tom** at the Pan Pacific Surgical Conference)

The new conservationist slogan says, "Eat a beaver and save a tree." (Told by **George Suzuki**)

The windy MC is handed a note with the word, 'KISS.' Puzzled, he returns it to the sender for clarification. The reply was terse: "Keep It Short Stupid!" (As heard by **Irene Wong**)

Bulletins

Doug Bell II, chairman of the Hawaii Heart Association's research committee is accepting applications for research projects in cardiovascular and related fields for the fiscal year July 1, 1975 to June 30, 1976...

Malcolm Todd, AMA president says there's a very definite correlation between rising unemployment and increased alcoholism...

HEW Secretary **Caspar Weinberger** feels that "the growing problems of the physician encounter when seeking medical malpractice insurance is a major crisis problem... While medical malpractice insurance is not normally a federal responsibility, we (the Feds) cannot sit by and watch

a significant number of doctors be unable to get very necessary coverage... In addition, the rising premium costs are making medical care more expensive." Yet he speaketh with forked tongue for he also says, "While sophisticated attorneys may be credited for heavy damage awards by juries, many of the claims are justified... HEW is preparing standby emergency legislation which probably would guarantee federal reinsurance for consortiums of private insurance companies if they experienced unexpectedly heavy losses." Momroe E. Trout, M.D., member of the HEW's malpractice commission said some doctors are considering dropping their insurance coverage, turning over all possessions to their families and preparing for bankruptcy if they're sued... (Food for thought... We understand our peripatetic neurosurgeon **Ralph Cloward** has a somewhat similar arrangement.)

Miscellany

The first year med student Miss Jones was stunned when the anatomy professor asked, "What part of the human anatomy enlarges 10 times with emotion or excitement?" She blushed and stammered, "I—I refuse to answer that question." The prof stared back, "Miss Jones, the answer is the pupil of the eye. You did not study your assignment and you have a dirty mind... Moreover, I'm afraid you are in for a tremendous disappointment when you marry." (Retold from **Ed Childe's** repertoire)

An internationally known psychiatrist had been invited to address a medical convention on the subject of sex. The conference room was filled to capacity with MD's eager to learn the latest in sex psychiatry... The famed, succinct scholar strode solemnly to the podium, adjusted his glasses, and sipped from a glass of water. A hush fell over the crowd. He looked up, and said in a firm clear voice, "Gentlemen, it gives me great pleasure," and sat down... (From **Claude Claver's** repertoire...)

Hors de Combat

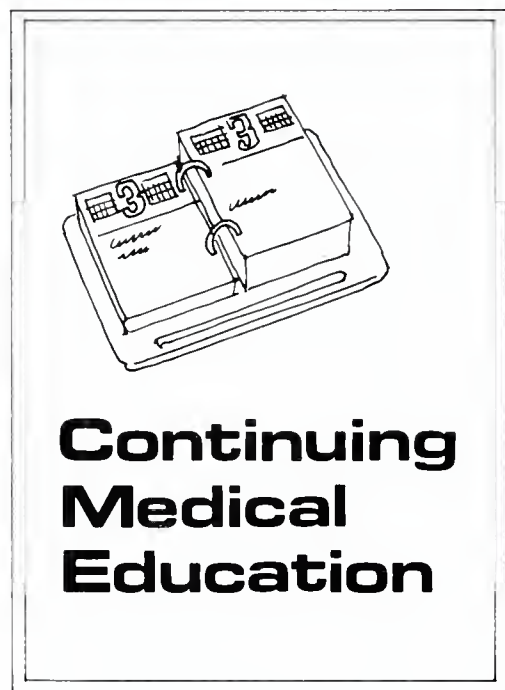
Perils of Acupuncture: Since the 1974 Legislature passed Act 206 making acupuncture legal, the number of acupuncturists here have been growing by leaps and bounds. The still unformed Board of Acupuncture examiners calls for three acupuncturists and two lay members, none of whom need be physicians. HMA exec secretary **Tom Thorson** complains, "They set up the board and took it out of the practice of medicine... There is no protection for the public... No government agency is controlling it... They are not licensed... Anybody can go into the business..." MD acupuncturist **H.Q. Pang**, president of Hawaii Acupuncture Science Research Foundation Inc suspects that some unqualified persons are practicing acupuncture in Honolulu. "I think some fly-by-nights are operating... Doctors are not against people practicing acupuncture... What we want is that they be carefully regulated; that they use sterile techniques... Some of these people come here from the Orient and put up their shingles and start practicing and there is no way to check them out..."

Drug Warnings: The JAMA editorial of Feb. 10 has revived the old UGDP issue on Orinase and estimates possible premature deaths of 10,000 and 15,000 a year of patients on hypoglycemic agents (of which there is an estimated 1.5 million Americans on these drugs). The FDA recommends, as it always has, that the drugs be used only when dietary control is impossible and use of insulin is impractical. The editorial merely stirs up the old controversy and we shall be plagued by unhappy diabetic patients who despite all our coercing, threatening and cajoling are totally incapable of staying on a diet permanently and who will eat themselves to a frenzy in their frustration. (We feel that rather than coming out with inconclusive controversial reports and editorials, which merely confuse the public, there should be a moratorium on such news till conclusive data is obtained...)

Along comes a UH Med School professor of biochemistry, Dr. N.V. Bhagavan, who warns that aspartame, a new artificial sweetener (which has been approved by our FDA), can cause damage to unborn babies of mothers who have or are carriers of PKU, and to PKU children under 6... He warns that "It can even damage the fetuses of normal mothers, if they consumed a large quantity of aspartame during the early weeks of pregnancy... This could turn out to be another thalidomide tragedy." Aspartame is 59% phenylalanine...

Curt A. Ries and Mervyn A. Sahud of the University of California in San Francisco report that Chinese herbal medicines illegally imported into the US for treatment of rheumatism, neuralgia, arthritis, back pains, improved blood circulation and sexual rejuvenation contain Aminopyrine and Phenylbutazone, Chinese herbs and other exotic substances, such as scorpion, tiger bone, rhinoceros horn, turtle shell and male mouse droppings...

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Continuing Medical Education

ELIZABETH K. ANDERSON, M.D.

Institution and Hospital Accreditation Activities:

Kapiolani Hospital was surveyed on March 4, 1975 for accreditation by an HMA team consisting of Drs. Roy Kamada (Chairman), Ivar Larsen, Ray Huffman and Paul McCallin.

Kuakini Hospital has submitted completed forms requesting accreditation and will be scheduled for survey of its CME program soon.

A review of the California system of *Patient Care Audit* was heard on February 7, and a film on this is in the HMA Office.

Calendar of Accredited Events

(One unit AMA credit for CME for one hour of program excluding 'breaks')

LOCAL:

On-Going:

Kauaikeolani Children's Hospital:
1. Weekly Grand Rounds

2. Weekly Monday Noon Seminars

3. Visiting Professor Program

4. April 2-4, Post-Graduate Pediatric Symposium

Special Events:

March 16 "Management of Heart Disease in Elderly" at Straub Clinic Conference Room; sponsored by Western Division American Geriatric Society, Straub Clinic, HMA: 8:00-3:30 p.m.
Contact L. Clagett Beck, M.D. for more information

(6 units Category 1 AMA credit; 6 units Class II AAFP credit)

March 16-22 Seminars in Sexual Counseling—"Brief Therapy Approaches to Office Management of Sexual Problems"
Princess Kaiulani Hotel
American College of Ob-Gyn; Kapiolani Hospital (also April 13-19)

March 23 "Symposium on Sleep Disorders" by William C. Dement, M.D., Ph.D. and Stanford University Sleep Disorders Clinic
Tripler Army Hospital Conference Room 2-B; 9:00-12:00 p.m.
Sponsored by Hawaii Psychiatric Society and HMA
Contact George Schnack, M.D. for more information

April 12, 13 "Update on latest developments in Internal Medicine"
Kahala Hilton; Hawaii Regional Meeting
American College of Physicians
Contact Bernard W.D. Fong, M.D. for more information
(8 hours instruction & credit)

California-Sponsored Courses in Hawaii:

April 5-10 "Orthopedics"—USC at Mauna Kea Hotel, Kamuela, Hawaii

April 5-12 "Pediatrics"—USC at Kona Surf, Kona, Hawaii

April 21-25 "Emergency Medicine"—USC at Kona Surf, Kona, Hawaii

April 21-25 "Diagnostic & Therapeutic Skills"—USC at Mauna Kea Beach Hotel, Kamuela, Hawaii
For further information on all of the above, contact:

Phil Manning, M.D., Associate Dean
Postgraduate Division
University of Southern California School of Medicine
2025 Zonal Avenue
Los Angeles, CA 90033

April 26-May 3 "Management of Surgical Patient"—Stanford at Mauna Kea Beach Hotel, Kamuela, Hawaii
For further information, contact:

Edward Rubenstein, M.D., Associate Dean
of Postgraduate Medical Education, M121
Stanford University Medical Center
Stanford, CA 94305

OUT OF STATE:

AMA Regional CME Programs— 8 Courses offering Category 1 credit

- 1) Dermatology for Non-dermatologists
- 2) Infectious Diseases & Antibiotics
- 3) Fluid & Electrolyte Balance
- 4) Venereal Disease
- 5) Pulmonary Function & Blood Gases
- 6) Basic & Advanced Support CPR
- 7) Basic ECG
- 8) Human Sexuality



H. TOM THORSON

Malpractice insurance problems mount as more and more states are denied coverage. A court order in Maryland orders St. Pauls to withdraw order of cancellation scheduled for April 1. Florida has filed suit against Teledyne for conspiracy with Argonaut for breach of contract. Similar actions are forming in other states. Such actions are understandable but do not solve the problem. Legislation has been introduced to help the situation here. All members are urged to communicate with their legislators urging support for the following legislative measures:

1. HB 1876 and companion bill SB 1730 providing for the setting up of a pooling or joint underwriting arrangement. This provides that the insurance department may ask all casualty companies to participate in a joint underwriting program and is designed to assure availability of coverage. (This is considered a stop-gap measure.)
2. HB 1899 companion SB 1389 providing for mandatory arbitration before trial. This bill will insert a mandatory arbitration procedure into the process before a case can go to trial. (This is important.)
3. HB 1838 and companion SB 1390 providing immunity for peer review committees and allowing them to communicate with other committees and with governmental agencies such as the Board of Medical Examiners. (This is a long term measure to strengthen the position of the Peer Review committee program.)

A Medical Injury and Claims (no-tort) bill, SB 1369 has been introduced and is under study. Its full implications are not yet understood. It was introduced by Senator Yamasaki.

SB 1387 provides for no loss except for "gross negligence" and also limits the time for actions to be commenced to two years from date of

occurrence. (This is "By Request" but we do not know who requested it.)

At this point, applications are still being accepted by Argonaut. We have had no information that termination is imminent.

Rate Changes will take effect practically immediately. The change will result in a 40-45% increase in rates. This is not the result of request by Argonaut, but rather through the Insurance Commissioner and the rating bureau, taking into consideration the total picture in Hawaii as well as the probability of a stabilization fund requirement under the joint underwriting bill. At this point we are unable to give effective rebuttal to this proposal because the experience of the HMA group has not been recognized as a separate entity. Proposals to remedy this are being prepared but will not be possible of enactment this session. Other measures relating to items of interest are:

LEGISLATION WE ARE SUPPORTING:

HB 60—amends the present law to allow minors to consent to medical services in connection with venereal disease, pregnancy, and family planning services without parental consent (excludes abortion). Minors would assume financial responsibility for costs of care. Counseling of patient encouraged to open lines of communication between parent and child.

HB 990—favor the transfer of responsibilities previously assigned to the Substance Abuse Agency to the Department of Health and concur with the establishment of a division of substance abuse.

SB 16—favor the establishment of a Hawaii Health Facilities Authority to oversee Act 97 Hospitals, but strongly urge that "breathing period" be allowed to allow fair opportunity for reaching financial independence.

SB 177—favor decriminalization, but do not favor legalization, of penalties relating to marijuana.

Medical School: Strongly reaffirmed support for a four-year medical school of excellence for Hawaii if economically feasible.

School Health Program: Strongly support the development of a *permanent* School Health Program for the State.

Payments to Physicians in the Medicaid Program: Have strongly urged the Legislature to appropriate an additional \$4.6 million which will allow the Department of Social Services to pay physicians 100% of the 75th percentile (which is allowable by Federal regulation).

Breast Cancer Project: We support appropriation of \$65,000/year for Breast Cancer Project of Cancer Society and Pacific Health Research Institute.

LEGISLATION WE CANNOT SUPPORT:

HB 382, SB 251

HB 1135, SB 982 requiring the *mandatory* re-

porting of cancer by physicians. HMA believes the present voluntary system of reporting is working well.

Chiropractic: HMA cannot support the inclusion of chiropractic care in prepaid health insurance plans, and other insurance plans, and medical care provided by the Department of Social Services.

HB 367/SB 802—amendment would circumvent the prohibition of unilateral substitution of generic drugs by allowing the pharmacist to substitute freely unless specifically restricted by the physician. Would not assure the physician that the substitution will be safe or that the patient will realize a cost saving by his maneuver and would expose the patient to the hazard of uncritical drug substitution.

Physician's Assistant Program: HMA believes a current assessment of the need and job opportunities available to physician's assistants should be made prior to implementation of program and believes primary objective of the School of Medicine at this time should be the training of medical doctors.

SB 1094— would require any medical facility or physician to turn over its or his medical records to any patient who demands them, implying even that no copies may be retained. HMA strongly urges that this bill not be enacted because it would abrogate property rights without due process and be detrimental to patients' health and health care.

Mental Health: Various bills suggesting changes in commitment procedures to psychiatric facilities as well as certain admission and hearing procedures have been opposed due to no evidence of need and the costly nature of such legislation.

Mental Retardation: Various proposals call for area plan for mental retardation: all agencies are urging careful review prior to any drastic measures.

Meetings With HEW have had to do with Medicare method of computation of fees. For some reason known to nobody, Aetna is using 1964 California RVS to compute fees. It has little effect on dollar amounts but it fouls up the coding. Everybody else in Hawaii is using the 1970 RVS. *BAIT* held out by Aetna to encourage acceptance of assignments is not very enticing. Bob Grathwohl didn't seem to have his heart in it when he presented what seemed to be a canned appeal from HEW to the HCMS Board of Governors.

AMA has filed suit against HEW relative to regulations concerning nursing homes. An additional suit will be filed relative to the Health Systems Planning bill.

California Medical Association rejected a

resolution repealing the "unit" membership provision and retained the requirement that membership in CMA included County Society, State, and AMA membership as a package. Vote was by voice vote in their House of Delegates.

Dues are due!!!

First Draft of PSRO proposal for operative PSRO has gone in.

Meeting on HMOs and IPAs (Individual Practice Associations) will be held in Albuquerque, New Mexico—April 19-20, 1975. Sponsored by American Association of Foundations for Medical Care, P.O. Box 230, Stockton, California 95201.

Governor Ariyoshi was principal speaker at the Honolulu County Medical Society March meeting on March 4. Before an audience of approximately two hundred doctors and their wives the Governor discussed various subjects ranging from public education to agriculture. The Governor made a firm statement of policy in favor of continuation of the Medical and Law Schools at the University. His position was based on his desire that students from Hawaii be given the opportunity to pursue a professional education here in Hawaii.

It was revealed at the meeting as well that the Governor has requested the HMA to submit nominations for the positions on the Board of Medical Examiners. This is a first time for the HMA to have input on the Board. Also stressed was the hope that agriculture could play a greater part in the economic future of Hawaii.

Governor Ariyoshi emphasized that he would be looking to the HMA for advice and counsel on matters related to medicine and health problems. He did point out that he might not always agree with HMA but he did respect the expertise of the physicians in regard to health care problems. It was reiterated that the state management of hospitals must be overhauled and re-examined.

Hilo Medical Group needs family practitioner, otolaryngologist, vascular surgeon. Write William L. Wong, 305 Wailuku Drive, P.O. Box 606, Hilo, HI. 96720.

Hawaii Society of Pathologists Meeting: Slide seminar April 4 8 pm at Straub Clinic (Frank Fukunaga)

BULLETIN "Nostalgia" First Annual KCH Building Fund program. Donation \$25.00 Sheraton Waikiki 6:00 pm Saturday, April 19, 1975. Professional talent as well as physician performers troubador Ed Dierdorf... including "Floating Ribs" and the singing Chairman, Edward Kagihara.

- a) Phoenix, Arizona (Mar. 15-16)
- b) Minneapolis, Minn. (July 26-27)
- c) Williamsburg, Virginia (Sept. 27-28)

For further information, write:

Department of Scientific Assembly
American Medical Association
535 North Dearborn Street
Chicago, IL 60610

also:

The Disabled Physician, April 11-12,
St. Francis Hotel, San Francisco, Calif.

American College of Physicians courses:

(For information, contact:

Registrar of Post Graduate Courses
American College of Physicians
4200 Pine Street
Philadelphia, PA 19104)

- | | |
|----------------|---|
| April
21-25 | ACP Course "Recent Progress in Clinical Endocrinology: Physiological Approach to Diagnosis & Treatment" |
| | Ann Arbor, Michigan |
| April
21-25 | ACP—"Physiological Basis for Management of Respiratory Insufficiency" |
| | Charleston, South Carolina |
| April
24-26 | ACP—"Gastroenterology for Practicing Physicians" |
| | Vanderbilt University, Tennessee |
| May
8-10 | ACP—"Selected Topics in Internal Medicine" |
| | Washington, D.C. Hospital Center |
| May
9-10 | ACP—"Latest Developments in Internal Medicine" |
| | Iowa City—University Hospital |
| May
14-16 | ACP—"Clinical Auscultation of Heart" |
| | Georgetown University Medical Center, Washington, D.C. |
| May
15-17 | ACP—Oregon Regional Meeting ACP "Latest Developments in Internal Medicine" |
| | Bend, Oregon |
| | For more information, contact:
Wayne Rogers, M.D., FACP
Medical-Dental Building
833 SW 11th Avenue
Portland, Oregon 97215 |
| May
15-17 | ACP—"Respiratory Pathophysiology" |
| | McGill; Montreal, Canada |

Other:

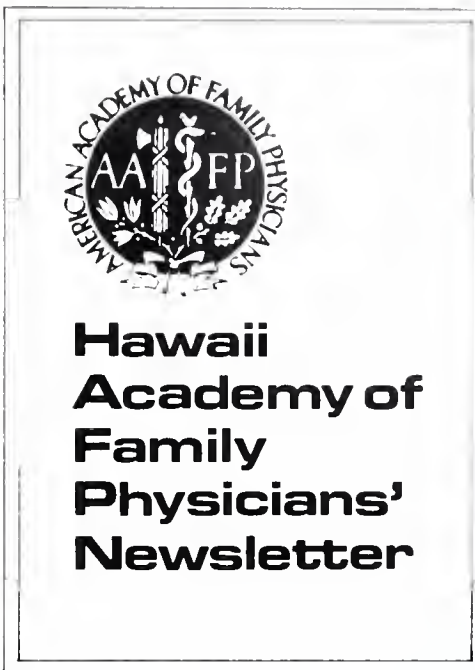
- March-August (12) Two-day Seminars on "Coronary Disease Exercise Testing," with supportive A-V materials
Various locations on mainland
(13 hours AMA credit; 13 units AAFP)
See CME Bulletin Board in HMA Office for details & locations.

California:

For further detailed listings of numerous Category 1 accredited CME courses taking place in California and other states, see CME Bulletin Board at the HMA Office of CME, and refer to the JAMA special issue on continuing medical education (August 1974).

Other Local: For listings of weekly lectures and rounds of *not yet accredited local institutions*, (but hours attended can be applied as Category 2 credits) see CME Bulletin Board in the HMA Office. We will have the weekly lecture/rounds/seminar topics of Kuakini, St. Francis, Queen's and other institutions posted as they are received.

Coming Soon: HMA Seminar on Possible Methods of relating quality assurance monitor programs to CME. Watch this space for announcements.



J. I. FREDERICK REPPUN, M.D.

New Members— Cas Jasinski has joined his spouse and our President Doris as a new Active member accepted in January. And, speaking of husband/wife teams we were delighted to note at the dinner meeting at Col. Brownlee's on 22 Feb that new member Patricia Dietrich has brought about a rapprochement that could hardly be more intimate between physicians and chiropractors by being married to Chiropractor D.L. Shaak! He has taken over Frank Trapani's office; Trapani and family left Hawaii to farm in the Pacific Northwest.

Necrology—We were much saddened by the news that Albert Shimamura, a member of HAFP since February 1952, died so soon after retiring from active practice. He had just been made a Fellow, AAFP.

News of Members—Bill Walsh still hasn't resumed practice. He attended the Congress of the Pan-Pacific Surgical Ass'n Thirteenth meeting and seemed to be in good spirits, despite having broken records and bones in his lifetime—43 of them! Buz Willett, long time on Lanai, is reported to have moved to California. James Langworthy has taken his place on Lanai. Tom Cahill has left the Pearl City Medical Associates to take over Fred Dodge's practice; Tom is now an Active member. Boh Millard and Ted Oto have become Life members. Fred Reppun was invited to be a guest speaker to the Minnesota AFP at their meeting in Kona the end of January while their patients and offices were buried in snowdrifts. Fred was given the topics of: "The Philosophy of a Generalist" and "Medical Politics in Hawaii". Don Farrell, our Pres-elect, will be attending the State Officer's Conference of AAFP in Kansas City this Spring. Harold Machigashira is the new Pohai Nani physician.

Special Announcement—Col. Bill Brownlee, head of the Family Practice Residency Program at Tripler, would like all members to consider the possibility of taking on a Resident for a month in the office early this year. There will be four (4) of these young, licensed, Family Practice-trained MD's to place. Please kokua and call Bill at 624-9370 if you are interested.

ABFP—Nicholas J. Pisacano, Exec Dir & Sec'y of ABFP has announced that the 1975 two-day written certification examination will be given in 5 centers on the Mainland 1 and 2 November 1975. The important thing to remember is the **Deadline** for applications: 15 June 1975. HAFP members who were certified by ABFP in 1974 were Don Hall, James Langworthy, Michael Padwick and Gerald Yorioka. 16 members of HAFP are diplomates of ABFP, which has held 5 annual examinations to date.

Council Action—The HAFP Council at its meeting of 6 February heard Ronald Berman, Ob-Gyn from Kapiolani,

present a case for a Regional Perinatal Care Unit in Honolulu and voted to support the concept. 10-15% of pregnancies lead to some 70% of "high risk" infants requiring intensive care. Salvage rate is increased when the high risk mother is transported with the baby still in utero to these specially equipped and staffed centers. Expense in dollars is high, however.

DSSH—Fred Reppun estimated that the "generous" increase in remuneration to physicians effective today will result in a 30% discount!!

JIFR



Hawaii Medical Library Acquisitions List for March 1975

ANESTHESIA

Anesthetic uptake and action, by Edmond I. Eger. Baltimore, Williams and Wilkins, 1974. QV 81 E29a 1974

Dental anesthesia and analgesia, by Gerald D. Allen. Baltimore, Williams and Wilkins, 1972. WO 460 A425d 1972

CARDIOVASCULAR SYSTEM

Exercise testing and training in coronary heart disease, by Jean Marie R. Derry. Baltimore, Williams and Wilkins, 1973. Oversize WG 141 D483e 1973

Myocardial infarction: new perspective in diagnosis and management, edited by Eliot Corday and H.J.C. Swan. Baltimore, Williams and Wilkins, 1973. WG 300 C794m 1973

A primer of cardiology, by George Edward Burch. 4th ed. Philadelphia, Lea and Febiger, 1971. WG 200 B94 1971

Vascular disorders of the extremities, by Irvin David Abramson. Hagerstown, Md., Harper and Row, 1974. WG 500 A161d 1974

COMMUNICABLE DISEASES

Control of the communicable diseases in man, edited by John E. Gordon. New York, The American Public Health Association, 1965. WC 100 A51 1965

Report of the committee on infectious diseases. American Academy of Pediatrics. Committee on the Control of Infectious Diseases. 17th ed. Evanston, Ill., 1974. Reference WC 1 AM145 1974

ELECTROMYOGRAPHY

Muscles alive; their functions revealed by electromyography, by John V. Basmajian. 3d ed. Baltimore, Williams and Wilkins, 1974. WE 500 B315m 1974

EMBRYOLOGY

Developmental anatomy; a textbook and laboratory manual of embryology, by Leslie Brainerd Arey. Rev. 7th ed. Philadelphia, Saunders, 1974. QS 604 A68 1974

ENDOCRINOLOGY

Diseases of metabolism, edited by Philip K. Bondy and Leon E. Rosenberg. 7th ed. Philadelphia, Saunders, 1974. WD 200 D91 1974

Endocrinology of woman, by Jose Botella-Llusia. Philadelphia, Saunders, 1973. WP 505 B748e 1973

EPILEPSY

Epilepsy: its phenomena in man, edited by Mary A.B. Brazier. New York, Academic Press, 1973. W 3 U17 no. 17 1973

GASTROENTEROLOGY

Gastroenterology, edited by Abraham Bogoch. New York, McGraw-Hill, 1973. WI 100 B675g 1973

HEMATOLOGY

Hematology for internists, by 26 authors. American College of Physicians. Editor, Robert I. Weed. Boston, Little, Brown, 1971. WH 100 A512h 1971

HISTOLOGY

Human histology; a textbook in outline form, by Leslie Brainerd Arey. 4th ed. Philadelphia, Saunders, 1974. QS 504 A683h 1974

LABORATORY DIAGNOSIS

Clinical laboratory methods, by John D. Bauer, Philip G. Ackermann and Gelson Toro. 8th ed. St. Louis, Mosby, 1974. QY 25 B82 1974

MEDICAL EDUCATION

Power and dissent in the medical school, by Samuel William Bloom. New York, Free Press, 1973. W 18 B655p 1973

MICROBIOLOGY

Textbook of microbiology, by William Burrows. 20th ed. Philadelphia, Saunders, 1973. QW 4 B97 1973

NEUROLOGY

The cranial nerve; anatomy and anatomico-clinical correlations, by Alf Brodal. 2d ed. Oxford, Blackwell, 1965. WL 330 B864h 1965

Essentials of the neurological examination, by Bernard J. Alpers and Elliott L. Mancall. Philadelphia, Davis, 1971. WL 141 A456e 1971

NEOPLASMS

Tumors of the head and neck; clinical and pathological considerations, by John G. Batsakis. Baltimore, Williams and Wilkins, 1974. WE 705 B334t 1974

NURSING

Nursing in society; a historical perspective, by Josephine A. Dolan. 13th ed. Philadelphia, Saunders, 1973. WY 11 D659 1973

OPHTHALMOLOGY

Biomicroscopy of the peripheral fundus; an atlas and textbook. Berlin, New York, Springer-Verlag, 1973. W 143 E33b 1973

OTO-RHINO-LARYNGOLOGY

Hearing and deafness, by Hallowell Davis and S. Richard Silverman. 3d ed. New York, Holt, Rinehart, and Winston, 1970. WV 270 D26 1970

Noise and man, by William Burns. 2d ed. Philadelphia, Lippincott, 1973. WV 270 B967n 1973

PEDIATRICS

Care of the newly born infant, by A.J. Keay and D.M. Morgan. 5th ed. Edinburgh, Churchill Livingstone, 1974. WY 159 C886n 1974

Child development; physical & psychological growth through adolescence, by Marian E. Breckenridge and E. Lee Vincent. 5th ed. Philadelphia, Saunders, 1965. WS 105 B82 1965

Resuscitation of the newborn infant and related emergency procedures in the perinatal center special care nursery; principles and practice, by Harold Alexander Abramson. 3d ed. St. Louis, Mosby, 1973. WQ 450 A16 1973

PHYSIOLOGY

Best and Taylor's physiological basis of medical practice. 9th ed. Baltimore, Williams and Wilkins, 1973. QT 104 B56 1973

PROSTAGLANDINS

The prostaglandins, pharmacological and therapeutic advances, edited by M.F. Cuthbert. London, Heinemann Medical Books, 1973. QU 90 C988p 1973

PSYCHIATRY

Early childhood psychosis; infantile autism, childhood schizophrenia and related disorders; an annotated bibliography, 1964 to 1969, prepared by Carolyn Q. Bryson and Joseph N. Hingtgen. Rockville, Md., National Institute of Mental Health, 1971. Reference ZWM 200 B916c 1964-69

Geronto-psychiatric literature in the postwar period; a review of the literature to Jan. 1, 1965. Chevy Chase, Md., National Institute of Mental Health, 1969. Reference ZWT I50 C576g 1965

PSYCHOANALYSIS

The patient speaks; mother story verbatim in psychoanalysis of allergic illness, by Harold Alexander Abramson. New York, Vantage Press, 1956. WM 460 A16 1956

RADIOLOGY AND NUCLEAR MEDICINE

Clinical application of physics of radiology and nuclear medicine, by Carl Robert Bogardus. St. Louis, Green, 1969. WN 415 B674c 1969

RESPIRATORY SYSTEM

Disorders of the respiratory system, by Gordon Cummings and Stephen J. Semple. Oxford, Blackwell Scientific Publications, 1973. WF 140 C971d 1973

SURGERY

Abdomen and rectum and anus. Edited by Charles Rob, Rodney Smith and Sir Clifford Naunton Morgan. 2d ed. Philadelphia, Lippincott, 1969. Oversize WO 500 R62 v.4-5 1969

Atlas of hand surgery, by Robert Arthur Chase. Philadelphia, Saunders, 1973. Oversize WE 17 C486a 1973

Demonstrations of physical signs in clinical surgery. 15th ed., edited by Allan Clain. Baltimore, Williams and Wilkins, 1973. WO 141 B15 1973

The history and literature of surgery, by John Shaw Billings. New York, Argosy-Antiquarian, 1970. WO 11 B593h 1895F

Operative anatomy of thorax, by Edward A. Edwards, Paul D. Malone and John J. Collins, Jr. Philadelphia, Lea and Febiger, 1972. Oversize WE 715 E26o 1972

Surgery of the shoulder, by Anthony Frederick DePalma. 2d ed. Philadelphia, Lippincott, 1973. WE 810 D41 1973

TOXICOLOGY

Environmental pollution by pesticides, edited by C.A. Edwards. London, New York, Plenum Press, 1973. WA 240 E5995 1973

Handbook of poisoning: diagnosis and treatment, by Robert Hastings Dreisbach. 8th ed. Los Altos, Calif., 1974. Reference QV 600 D77 1974

Laboratory diagnosis of diseases caused by toxic agents, compiled and edited by F. William Sunderman and F. William Sunderman, Jr. St. Louis, Green, 1970. QV 602 A652L 1970

Poisoning; toxicology, symptoms, treatments. 3d ed. Springfield, Ill., Thomas, 1974. QV 600 A68p 1974

TRAUMA

The management of trauma, edited by Walter F. Bal-

linger, Robert B. Rutherford, and George D. Zuidema. 2d ed. Philadelphia, Saunders, 1973. WO 700 B19 1973

Traumatic injuries of facial bones; an atlas of treatment, by John B. Erich and Louie T. Austin. Philadelphia, Saunders, 1944.

VIROLOGY

Clinical virology; the evaluation and management of human viral infections, edited by Robert Bebie and Josette Celers. Philadelphia, Saunders, 1970. WC 500 D288c 1970



Frederick Bennett Giles, M.D.

Queen's Medical Center
Honolulu, Hawaii 96808

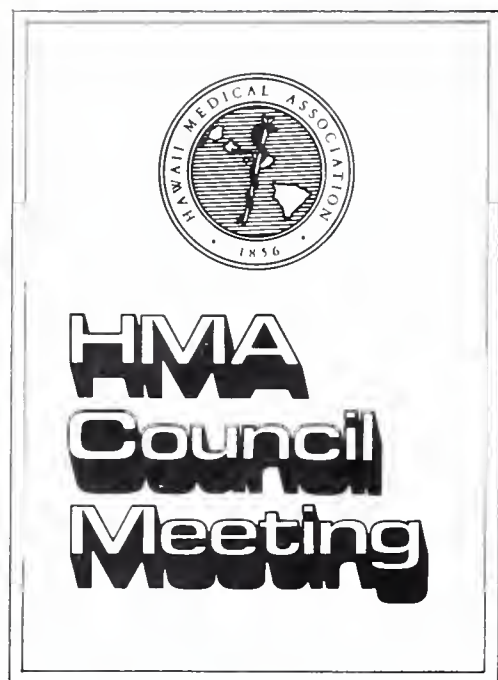
RADIOLOGY



Charles M. Aronsohn, M.D.

1010 South King Street
Honolulu, Hawaii 96814

INTERNAL MEDICINE



Friday, October 4, 1974, 5:30 P.M.
Mabel Smyth Lanai

CALL TO ORDER

The meeting was called to order by President Thomas P. Frissell. Present were Drs. Winfred Y. Lee, R. Varian Sloan, Grover H. Batten, Herbert Y.H. Chinn, George Goto, Douglas B. Bell II, Albert C.K. Chun-Hoon, William W.L. Dang, Sakae Uehara, Verne Adams, William Moore, Verne Waite, Calvin C. J. Sia, and Rowlin Lichter.

MINUTES

The minutes of the August 2, 1974, meeting were approved as submitted.

SECRETARY

The report of the Secretary was approved as submitted.

COMMITTEES AND COMMISSIONS

Public Health: A mass school immunization program planned by the Department of Health was discussed. It was suggested that representatives of the HMA meet with the Director of Health regarding the proposal and re-emphasize the HMA's position regarding a "medical home for all children".

PSRO: A progress report on PSRO developments was presented. Meetings have been held with representatives of the Trust Territory, Guam, and American Samoa and they are interested in participating in PacPSRO insofar as possible. There was some question regarding membership in the newly formed PacPSRO and whether the membership cards designating the Hawaii Foundation for Medical Care as the PSRO agency were valid. The Board believes the cards are valid but will consider the matter further.

ACTION:

It was voted to request copies of the PSRO Progress Reports for all Council members.

Medical Services: A public hearing on proposed changes in the medical fee schedule for Workmen's Compensation will be held in mid-October and will be effective January 1, 1975. Drs. Albert Chun-Hoon and Rowlin Lichter were designated to represent the Association at the hearings. It is proposed to recommend that (1) physician services be reimbursed on the basis of the usual, customary, and reasonable concept; (2) that the differential fee in the proposal be abolished; (3) that the 1970 Hawaii Relative Value Studies be adopted in its entirety; (4) that the use of the modal

conversion factors from the August 1974 survey of HMA members be recommended if factors at the present time prohibit the use of the UCR concept; and (5) that the Department of Labor be invited to cooperate in studying, developing, and keeping current, the Hawaii Relative Value Studies for use by the Workmen's Compensation Division and Workmen's Compensation carriers.

ACTION:

It was voted to proceed as outlined for the Workmen's Compensation hearings.

Emergency Medical Service (EMS): A planning grant for the Neighbor Island EMS Program will be submitted with March 1975 as the expected starting date. The communications system for the neighbor islands is expected to be installed in December. A grant from the University of Hawaii to train certain EMS personnel has been received and the program is in process.

Medical Research Task Force: This ad hoc committee was formed under the chairmanship of Dr. Herbert Y.H. Chinn to consider HMA involvement in various federally funded projects.

Physician's Action Group: A Physician's Action Group has been formed under the auspices of the Hawaii Society of Internal Medicine with representatives of the specialty societies and dentists and optometrists, to seek an increase in the level of fees under the Medicaid program. Dr. Frissell attended several of the meetings of the group and outlined their activities and negotiations with the Legislative Coalition. Dr. Frissell recommended support of the attempt to obtain more equitable reimbursement under the Medicaid program but felt that other matters under consideration were not germane in the negotiations.

ACTION:

It was voted to support the President's position. There was one opposed.

Finance Committee: The August financial report was accepted subject to audit. The proposed budget for 1975, to be presented to the House of Delegates at the annual meeting, was reviewed in depth. Separate detailed schedules were presented for the committee expenses, Roster, Journal, and Continuing Medical Education program.

ACTION:

The question of subsidizing the Journal was referred to the House of Delegates. It was voted to approve the budget for 1975 as proposed. It was voted to recommend that the dues for 1975 remain at \$205/member. It was voted to approve the recommendation of the Common Fund Committee that the cost sharing of the Common Fund be 60% (HMA)—40% (HCMS) for 1975.

OLD BUSINESS

After the last Council meeting, those who were in attendance were again polled regarding plans for a luncheon in lieu of the annual banquet at the HMA Annual Meeting. The poll indicated that a majority wished to reconsider and favored a luncheon for the 1974 meeting. The Convention Committee was instructed to proceed.

NEW BUSINESS

The Council thanked the President, Dr. Thomas Frissell, for his outstanding leadership during the last year and one-half.

R. VARIAN SLOAN, M.D., *Secretary*

Friday, January 10, 1975, 5:30 P.M.
Mabel Smyth Lanai

CALL TO ORDER

The meeting was called to order by President Winfred Y. Lee. Present were Drs. William W.L. Dang, Grover H. Batten, George H. Mills, Herbert Y.H. Chinn, George Goto,

J. I. F. Reppun, John Edwards (installed to complete the one-year term for Dr. Chun-Hoon), Carl Lum, Ann Catts, Rowlin Lichter, Sakae Uehara, Verne Adams, Peter Kim, Albert Chun-Hoon, and Marion Hanlon plus Calvin Sia, Douglas Bell II, and Elisabeth Anderson. Also present for the discussion regarding the Physicians, Dentists, and Optometrists Action Group were Drs. John Keenan, Raymond deHay, Bernard Fong, Fred Gilbert, Maurice Nicholson, and John Fujioka of the Dental Association.

MINUTES

The minutes of the October 4, 1974, meeting were approved as circulated.

SECRETARY

The report of the Secretary was approved as submitted.

REPORT OF THE TREASURER

The financial statement for November, 1974, was filed subject to audit.

ELECTIONS

Community Research Bureau: The annual meeting and election of officers of the Community Research Bureau was called to order by the Treasurer, Dr. Grover Batten. Officers of the Bureau were nominated and elected as follows: B. Allen Richardson, President; Theodore T. Tomita, Vice President; O.D. Pinkerton, Secretary; and Grover H. Batten, Treasurer.

Hawaii Foundation for Medical Care: Trustees for the Foundation were nominated and elected as follows: Henry Yokoyama, Peter Kim, and Sakae Uehara.

Bureau of Research and Planning: The President recommended the appointment of Dr. William E. Iaconetti as chairman of the Bureau of Research and Planning. The following were elected: William E. Iaconetti (Maui) (1977), Chairman; William Dang (1977); Richard Omura (1977); Fred I. Gilbert (1976); Wilbur Lummis (1976); and Verne Waite (Kauai) (1976).

Finance Committee: Nominations were submitted and the following were elected for one year terms: Marcelina Avella, Albert Chun-Hoon, Elmer Johnson, Richard Omura, and John Edwards.

Cancer Commission: The Council nominated Grover H. Batten to serve as the HMA Representative on the Cancer Commission. Dr. Batten was appointed to the Commission by the President and was asked to continue as chairman.

COMMITTEES AND COMMISSIONS:

Physicians, Dentists, and Optometrists Action Group: Representatives from the Physicians, Dentists, and Optometrists Action Group met with the Council to discuss mutual concerns regarding services to Medicaid patients and fees paid to practitioners for these services. A summary of the activities of the PD&O Group as well as the proposed agreement with the Legislative Coalition was presented by the chairman of the Group. In a letter to the Governor, President of the Senate and Speaker of the House, dated August 26, 1974, the HMA co-signed and supported the request for legislative action to permit a revision of fees and increased availability of services and reiterated that position in a letter to the Chairman of the PD&O Group in September 1974. At that time, however, it was pointed out that while HMA supported the activities regarding more equitable remuneration it could not support other activities of the PD&O Group.

The proposed agreement between the Action Group and Legislative Coalition was discussed at length. The Council agreed with many of the principles set forth in the document but agreed that the original goal and sole function of the Group was to seek equitable reimbursement of fees paid providers in the program. The Council further agreed that the HMA's Economic Evaluation and Adjustment Committee should work jointly with the PD&O Group toward that goal.

ACTION:

It was voted to reaffirm the position stated in the original letter dated August 26, 1974, and that the President transmit the feelings expressed at the meeting to the Physicians, Dentists, and Optometrists Action Group.

Medical Education and Peer Review: Mr. Tholson reported that there were serious professional liability insurance problems occurring throughout the United States and discussed impending problems facing the physicians of Hawaii.

ACTION:

It was voted to meet with representatives of the Argonaut Insurance Company as soon as possible.

Public Health: The School Health Committee recommended that the school health services program in the Department of Health be elevated to a division level rather than a branch of Child Health Services as presently constituted. This would place the school physician in line with the district superintendent level in the department of education.

ACTION:

It was voted to accept the recommendation and write to the Director of Health regarding this matter.

The Cancer Committee recommended that the HMA endorse the American Cancer Society's request to the State Legislature for supplemental funds of \$65,000 a year to meet unbudgeted needs in the Pacific Health Research Institute Breast Cancer Detection Project.

ACTION:

It was voted to support the recommendation.

The Cancer Committee also recommended that HMA support the action of the Executive Board of the Cancer Center of Hawaii in applying for a planning grant to fund the cancer control program.

ACTION:

It was voted to accept the recommendation of the Committee.

Health Services and Care: Copies of the testimony prepared for the hearing on the rules and regulations to Act 209, Comprehensive Health Planning, was reviewed.

ACTION:

It was voted to approve the testimony.

Medical Services: The commissioner announced the receipt of the newly adopted Workmen's Compensation Fee Schedule. This schedule adopts the five-digit coding of the 1970 Hawaii Relative Value Studies, removes the differential fees for specialists, and provides an adjustment in the level of fees. There are a few inconsistencies and the Workmen's Compensation Committee plans further review of the schedule.

ACTION:

It was voted to gratefully acknowledge the cooperation of the staff of the Department of Labor, and especially for the efforts of the Director, Mr. Robert Hasegawa.

A public hearing on the DSS Fee Schedule is scheduled for January 14. Dr. Chun-Hoon will testify regarding the level of fees proposed by the Department and Dr. Neal Winn will testify regarding preauthorization requirements proposed when prescribing controlled substances.

ACTION:

It was voted to present the testimony as circulated.

Legislation: The Hawaii State Legislature will convene on January 15. The House of Delegates did not mandate enactment of new legislation but it is expected that HMA will be involved in many of the health issues.

continued page 114

In Memorium

FORREST JOY PINKERTON, M.D. 1892-1974

Dr. Forrest J. Pinkerton's full and active life was brought to an end on December 29, 1974, by bronchogenic carcinoma, at the age of 82. Like many another Honolulu physician, he came to Hawaii in 1917, as a Lieutenant in the U.S. Army Medical Corps, and left the Army in 1919, as a Major, to enter the private practice of eye, ear, nose & throat (as it was then called) in Honolulu.

Born in Lowell, Indiana, January 23, 1892, he studied medicine at the Chicago College of Medicine and Surgery (later Loyola) from which he graduated in 1914.

He joined the Honolulu County Medical Society as soon as he had obtained his license to practice here, in 1919. Evidently he interested himself promptly in the Society's affairs, because in 1924 he was elected president of it. He then became secretary-treasurer, and in 1929 was again elected president, following which he was elected corresponding secretary, and then secretary-treasurer. From 1926 to 1951, he was a member of the Council of the Territorial Society, and during these years he also served on a wide range of committees. He was twice chairman of the effective committee on public policy and legislation, and was chairman of the fee schedule committee that assembled the first relative value schedule in America—only to see it rejected as the result of an internecine quarrel and turned over to a California Medical Association committee, where it sparked the famous California RVS programs.

Dr. Pinkerton's energetic and efficient development of the Hawaii Blood Bank, started in 1941 in timely preparation for the Pearl Harbor attack, deserves the fullest credit. He knew, before the end, that its building had been named as a permanent memorial to him.

Dr. Pinkerton also made his mark for his able management of the still extremely useful Public Health Fund of the Honolulu (now Hawaii) Chamber of Commerce; as the long-time chairman of its public health committee, he managed this fund effectively for several years.

Dr. Pinkerton was delegate from Hawaii to the AMA House of Delegates, in which Hawaii was afforded full states' rights long before statehood was conferred upon us. He served as delegate entirely at his own expense; not until 1944 did Hawaii start paying its delegates' expenses.

"F.J."s committee activity in the county medical society continued almost to the end: from 1971 through 1973 he was an active member of the disaster committee, to which his long experience was of course invaluable.

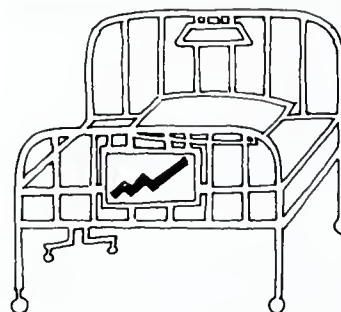
In 1928, Dr. Pinkerton helped found the Pan-Pacific Surgical Association, and as its secretary-treasurer from 1929 to 1948, and Director General, from 1951 to 1963, he was to a great extent responsible for its spectacular success as an international surgical forum.

He was a Fellow of the American College of Surgeons, a diplomat of the American Boards of both otolaryngology and ophthalmology, and a member of the American Academy of Ophthalmology and Otolaryngology, the American College of Chest Physicians, the American Laryngological Society, the American Laryngological, Rhinological, and Otological Society, and the American Bronchoesophagological Association. He had received presidential citations from Presidents Roosevelt, Eisenhower, Johnson, and Nixon. In 1965 he received the coveted "Order of the Splintered Paddle" from the Honolulu Chamber of Commerce, and in 1973 he received Hawaii's Native Born Citizen of the Year award.

He was a member of the Pacific, and MidPacific Clubs, the Hawaiian Lodge No. 21, F. & A.M. (Past Potentate) and the Scottish Rite. He is survived by his wife, Florence, his brother, Ogden, another brother and two sisters, and two sons by his first marriage: Robert C. Pinkerton of San Jose, California, and David E. Pinkerton of Tacoma, Washington.

If any Hawaii physician since Dr. John S. McGrew in the 90's has deserved the title of Mister Hawaii Medical Association, it has surely been Forrest Joy Pinkerton. He will be missed.

HLA



Hospital News

Saint Francis Hospital

Dr. Lawrence Wong has been elected chief of staff and president of the Executive Board at St. Francis Hospital, succeeding Dr. Francis Won.

Elected to serve with Dr. Wong were Dr. Albert Chun-Hoon, vice president; Dr. Walter W.Y. Chang, secretary; and Dr. Raymond Fujikami, treasurer.

Chiefs of departments also serving on the Executive Board are Dr. Livingston Wong, surgery; Dr. H.H. Chun, medicine; Dr. Francis Soon, gynecology; Dr. Walter Wakatsuki, dentistry; and Dr. Robert Ballard, general practice. Other members are past president Dr. Francis Won and members-at-large Dr. Winfred Lee, Dr. William Dang, Dr. L.Q. Pang, Dr. Carolina Wong and Dr. Herbert Chinn.

Notes and News continued from 100

The JAMA also reports that birth control pills significantly increases the risk of stroke in women. With normal blood pressure, the stroke risk is 3 times higher; and with severe high blood pressure, the risk of thrombotic stroke is 2 times higher. When the pill is correlated with smoking and migraine, there is a slightly enhanced risk of hemorrhagic strokes, but not thrombotic strokes. The study included 598 nonpregnant stroke victims from 15 to 44 years old and was done by the Collaborative Group for the Study of Strokes in Young Women (including 10 physicians and medical scientists from several universities and the NIH). (So there we have it... It seems that practically everything we have prescribed for the last 10 to 15 years, except for Chinese herbs may be potentially hazardous...)

The National Cancer Institute announces that women in the first trimester should shun beef liver which contains residue of DES (diethylstilbesterol) (used to fatten cattle) because of an increased incidence of uterine CA in daughters of DES exposed mothers (the incidence is as high as 4 per 1,000).

A John R. Lightfoot of Pasadena, California suggests in a letter to the editor: "Medical school or not a medical school. Who is to pay for it? I don't know if the taxpayer should or perhaps the practicing physician. After all, he received most of his education, including medical school, on the taxpayer...one way or another. Now that they are charging so very much for their services, perhaps they can return a good portion of their income to help educate another prospect..."

Star Bulletin Editorial of Feb. 18, '75 "Safest for the Doctor: A Star Bulletin editorial referred to Public Health Service statistics that show abortion is safest for the mother if performed during the first three months of pregnancy. The very next day, a jury verdict in Boston showed it also is safest for the doctor. A jury found a doctor guilty of manslaughter because he permitted the death of a fetus well-enough developed that it showed signs of life outside the womb. While there may at times be urgent reasons for abortions after the first three months, the case for deciding to perform an abortion early, if at all, is quite compelling." (The editorial writer forgets that it is the patient who must first come to the physician with her problem... No physician deliberately delays an abortion...)

New York orthopods now pay at least \$14,500 annually and Argonaut is threatening to cancel their contracts unless they pay 198.6% more in premiums by Jan. 10. These orthopods are planning a protest march on the State legislature in Albany on Jan. 13...

Robert Millar, State Medicaid director says DSSH will increase Medicaid payments by 20% on March 1 (which will add \$2 million to the \$11.6 million budget of which 44% is federally funded). HCMS prexy **Al Chun-Hoon** testified before the Senate Health Committee that the increase was totally inadequate and that it should be the usual and customary fee charged by 75% of the physicians. The State is offering to pay ¾ of the fee charged by the 75 percentile. Bob says 85% of the physicians are treating Medicaid patients for various ailments (a doubtful figure), but we agree with Bob that "welfare patients are difficult to treat... They often do not keep appointments and do not follow a physician's orders... They are demanding of a doctor's time and frequently call him at odd hours with minor problems which they have had for days..."

Miscellany

Straight from the hills of the Ozarks came Pollyann to the admitting office of a big city hospital. "I want to see an up-tum," she told the nurse on duty. "Oh, you must mean an intern." "I want a contamination." "You mean an examination," corrected the nurse again. "Maybe so, but I want to go to the fraternity ward." "Maternity ward," said the nurse. "Look," insisted Pollyann, "I haven't demonstrated in 3 months and I think I'm stagnant..." (As told by our tennis playing architect friend **Dick Dennis**)

A 90 year old man was in for a checkup. The doctor reassured him, "You're in great shape." "I know, but I have one complaint. My sex drive is too high. Can you fix that?" The doctor was amazed. "Your what?" "My sex drive... It's too high and I'd like to have it lowered." "Just what do you consider too high?" "Well, these days it's all in my head, Doc, and I'd like to have you lower it, if you can." (In memory of **Al Shimamura** who told it at a Kuakini Staff party)

Community News

A site visit team of the National Liaison Committee on Medical Education advised Dean **Terry Rogers** that the U of H Med School will be recommended for accreditation for three years, instead of the usual two years granted to new 4 year schools because of the school's outstanding progress.

Xeroradiography machines developed by the Xerox Corp were installed at the Straub Clinic, the Honolulu Medical Group and at Kuakini Hospital.

Sparky Matsunaga predicted at a "Public Policy for Health" seminar by the U of H School of Public Health that "the 94th Congress will enact legislation very much like the proposed National Health Security Act and take a giant step toward assuring every American the basic right to health care."

Testimonial Dinner for Ira Hirschy

(Pagoda International Ballroom 1-11-75)

John Gooch the principal speaker was at first apologetic... I don't know if I'm the right speaker... You know having the right speaker is like taking the right medicine... Which reminds me of a joke... You know I used to practice and took care of dogs and cats... One day, Joe the farmer sez, "Hey Doc... Give me some more of that medicine for the bull... Remember the time the bull wasn't taking care of the cows?" Well, I had two kinds of pills for that so I asked which one? "You know, those pills that tasted like peppermint..." Then John was serious when he said, "We appreciated Dr Hirschy for his thoughtfulness, his patience, his understanding and sense of humor..." Then John launched into a biographical sketch from which we jotted the following desultory notes: "Ira has an interesting background... His parents were school teachers with 40 acres of Indiana farm and then moved to a 160 acre Iowa farm. He had an innovative grade school teacher... and passed the 6th grade exam at age 11. He matriculated to high school... Then on to Jamestown College in N. Dakota... He worked his way through college as a waiter... and earned a B.S. in biology... One winter day while driving a horse drawn wagon, a big sack of sugar busted in the snow. Ira shoveled the snow-sugar into a pot which he boiled down and the family had syrup for pancakes all winter..."

Re the famous Hirschy stride... "He walked to school... 1 mile in 12 minutes... ie walking at 5 miles an hour. Now it's slowed down to 6 miles/hr..."

"Ira went on to the U of Michigan where he earned a Masters in zoology. In 1933 he finished medical school and interned in the Canal Zone... There was a rabies patient in the hospital. The nurse had just given the patient his shot and was leaving the room with a hypodermic syringe in her hand... when she accidentally inoculated Ira in his arm. So Ira had to take the whole painful series of inoculations... which is probably why he is such a strong supporter of the quarantine system... Ira was first exposed to Kalaupapa in 1941... He then returned to U of M for a Masters in epidemiology in 1942... In 1951 he was in charge of the Leprosy program... In 1961, he became head of Communicable Diseases... Patients at Kalaupapa when interviewed, expressed appreciation for Dr Hirschy's ability and understanding... The image that Dr Hirschy gives... He is photogenic... His nicknames, "Great White Father", "Big

Daddy"...Believe me, those names were given with fondness..."

"Big Daddy" seemed strangely reticent and his eyes sparkled... When he received a chess set... he commented, "I learned to play chess during... you know the ole army game... hurry up and wait..." When he was finally given an opportunity to respond to the gifts and praises, he said, "Now may I defend myself?" Then he took this opportunity to praise the work at Hale Mohalu and the loyal staff there... "For many years Hale Mohalu has been unnecessarily maligned... Hale Mohalu is where our observations and trials on leprosy treatment were conducted... We observed bacteria granules in 1960... In 1965, we concluded that perhaps the bacteria were getting old... We gave a trial of 3 months, then 6 months... Then in 1968, the regulations were changed and the patients were sent home... 1970 or 1971... was the next big break... New drugs from Carlisle—A drug which made people dark—was first tried on 12 patients for 1 year. Then a new drug for Tbc was used... It became unnecessary to isolate or hospitalize patients... All those things were worked out at Hale Mohalu... The loyal staff... They deserve recognition for sticking it through thick and thin..."

Doctors in Print

Howard Liljestrand is co-author of a handy little traveler's booklet, "Go In Health, A Health Guide for the Casual Traveler." "The booklet covers old wives tales exploded, protection before you leave, protection on your way, preventive medicine treatment, precautions and personal medical kit."

Conference Notes

Jerome Vaeth, director of the West Coast Cancer Foundation and Chief of the Department of Radiation Oncology, St. Mary's Hospital, S.F. spoke at Kuakini on Radiation therapy for Intraoral and laryngeal CA"...

Re lesions of the oral cavity, lips, tongue: surgery for small lesions.

Lips: Plastic surgery if involving less than 1/3 of the lip; if more than 1/3 then, radiation Rx. *Tongue:* Anterior 2/3, radium implant after external radiation. Linear accelerators are replacing Betatrons. *Larynx:* In general radiation therapy combined with surgery is effective. *Supraglottic lesions:* Good results with radiation for T1 and T2 lesions. *Re indirect laryngoscopy:* Jerome warns that women used to sit side saddle for the exam, but nowadays they sit straight and many wear no panties. So keep their legs together and straddle with your knees.

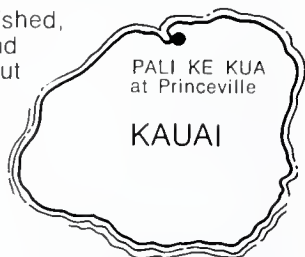
Grant Stemmerman at the Pan Pacific Surgical Conference: The incidence of gastric ulcer to duodenal ulcer is 4:1 in Japan. Intestinalization is common in Japan, even in the 20's... Distal intestinalization is common in high risk populations. *Incidence of gastric Ca in Japan:* Female predominance up to age 45. *Types of gastric Ca:* In high risk populations, intestinal type Ca predominates. In low risk populations, diffuse type, esp in women and in young people. In the second generation Japanese in Hawaii, there is less of the intestinal form. ■

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**Hawaii
Heart
Association**

Auction Raises 7,500 For Heart Association

Some \$7500 was raised from the March 2 Antique, Fine Arts and Jewelry Auction held at the H.I.C. Exhibition Hall. All the proceeds were donated to the Hawaii Heart Association, reported Mr. Bob Bourell, promoter of the auction and show.

More than 100 items were auctioned off with bids ranging from \$3 for an English pitcher to a 1600 A.D. French oil painting selling for \$750. All the items were donated by the Show's exhibitors and Mr. Steve Rosen and Mr. Lou Stambler donated their time as auctioneers for the Sunday afternoon fund raiser.

"Gentlemen, congratulations are in order."



"A.H. Robins asked me to compare the banana flavor of their Donnagel® -PG with the real thing and, by jove, I couldn't tell the difference. Not even in sip-by-sip comparison. Amazing!"

"There's no unpleasant paregoric taste because there's no paregoric. Clever, wouldn't you say? Instead, A. H. Robins uses the therapeutic equivalent, powdered opium, to promote the production of formed

stools and lessen the urge. And Donnagel-PG also provides the demulcent-detoxinant effects of kaolin and pectin, plus the antispasmodic benefits of belladonna alkaloids.

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"May I propose a toast?"

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Pectin	142.8 mg
Hyoscyamine sulfate	0.1037 mg
Atropine sulfate	0.0194 mg
Hyoscine hydrobromide	0.0065 mg
Powdered opium, USP	24.0 mg

(equivalent to paregoric 6 ml.)
(warning: may be habit forming)

Sodium benzoate, (preservative)	60.0 mg
Alcohol, 5%	

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TRACT
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For unproductive coughs

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Glyceryl guaiacolate 100 mg
Alcohol, 3.5%

For severe coughs

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Each 5 cc. contains:
Glyceryl guaiacolate 100 mg.
Codeine phosphate 10.0 mg
(warning: may be habit forming)
Alcohol, 3.5%

Non-narcotic for 6-8 hr. cough control

ROBITUSSIN-DM®

Each 5 cc. contains:
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Dextromethorphan hydrobromide 15 mg.
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Robitussin-DM in solid form for "coughs on the go"

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Phenylpropanolamine hydrochloride 12.5 mg.
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ROBITUSSIN®	<input checked="" type="radio"/>				<input checked="" type="radio"/>
ROBITUSSIN A-C®	<input checked="" type="radio"/>	<input checked="" type="radio"/>			
ROBITUSSIN-DM®	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>		<input checked="" type="radio"/>
ROBITUSSIN-PE®	<input checked="" type="radio"/>			<input checked="" type="radio"/>	<input checked="" type="radio"/>
ROBITUSSIN®-CF	<input checked="" type="radio"/>	<input checked="" type="radio"/>		<input checked="" type="radio"/>	<input checked="" type="radio"/>
COUGH CALMERS®	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>

H.M.A. Council Meeting from page 107

Cancer Center: Dr. Chinn reported on the progress of the Cancer Center and now serves as the chairman of the Executive Board for the Center.

Cancer Commission: A letter received from the National Cancer Institute relative to the operation and lines of communication between the Hawaii Tumor Registry, Cancer Commission, and Cancer Center was discussed at length. The present contract with the Research Corporation has expired and there are questions regarding its renewal. It was suggested that the Executive Board look into this matter in depth and meet with Mr. Myers when he visits in late January. It was also recommended that the Hawaii Medical Association reaffirm their original position expressed in 1959 that it owns the Registry. It was also recommended that the President recommend the two SEER representatives who will represent Hawaii Tumor Registry.

ACTION:

It was voted to approve the recommendations.

Medical Research Task Force: It was reported that the Task Force is presently reviewing federal projects which might be of interest to the association.

Site Committee: The site previously of interest to the association is no longer available. The committee will continue to seek a new site.

PSRO: Dr. Lee reported that nine policy statements have been developed by the PSRO Board and they are presently meeting with each hospital to discuss funding. A representative from Washington will meet with the board on January 13 and all members of the Council are invited to attend.

PL 93-641: The National Health Planning and Resources Development Act of 1974 was signed into law on January

3. This law will abolish the presently constituted organizations of RMP, CHP, and Hill-Burton Administration and combine the functions of these organizations under one agency. A meeting will be held in San Francisco on January 23-24 regarding this new legislation. Since there will be at least three representatives in the area at that time, it was voted to send these representatives to this meeting.

NEW BUSINESS

President's Message: Dr. Lee announced that he would like active membership participation in the association and reported that he had met with the committee chairmen and commissioners to discuss goals and objectives for 1975. It was agreed that the Council should meet on a regularly scheduled date and the second Friday of each month was selected. Dr. Lee also noted he would especially like to meet with neighbor island societies, particularly if there are specific problems affecting the association.

USP Convention: The HMA delegate to the United States Pharmacopeial Convention is Dr. Daniel Palmer. The quinquennial meeting of the USP Convention will be held in Washington D.C. in March and Dr. Palmer has requested travel funds.

ACTION:

It was voted to approve the travel request.

Information Material: Various copies of HMA correspondence relating to the prescription drug hearings and no-fault malpractice was circulated to the Council.

ADJOURNMENT

The meeting adjourned at 11:00 p.m.

R. VARIAN SLOAN, M.D., *Secretary*

Our “Angels”

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re prescribing, see complete prescribing
mation in SK&F literature or *PDR*. The
wing is a brief summary.

ications: Edema associated with congestive
t failure, cirrhosis of the liver, the nephrotic
rome; steroid-induced and idiopathic
na; edema resistant to other diuretic ther-
Also, mild to moderate hypertension.

raindications: Pre-existing elevated serum
ssium. Hypersensitivity to either com-
nt. Continued use in progressive renal or
tic dysfunction or developing hyperkalemia.

arnings: Do not use dietary potassium supple-
ts or potassium salts unless hypokalemia
lops or dietary potassium intake is markedly
ured. Enteric-coated potassium salts may
e small bowel stenosis with or without
ation. Hyperkalemia (> 5.4 mEq/L) has
reported in 4% of patients under 60 years,
1% of patients over 60 years, and in less
8% of patients overall. Rarely, cases have
associated with cardiac irregularities.

ordingly, check serum potassium during
py, particularly in patients with suspected
nfirmed renal insufficiency (e.g., elderly or
etics). If hyperkalemia develops, substitute
azide alone. If spironolactone is used con-
tantly with 'Dyazide', check serum potas-
i frequently — both can cause potassium re-
on and sometimes hyperkalemia. Two
hs have been reported in patients on such
ined therapy (in one, recommended dosage
exceeded; in the other, serum electrolytes
not properly monitored). Observe patients
'Dyazide' regularly for possible blood dys-
ias, liver damage or other idiosyncratic
ctions. Blood dyscrasias have been reported
tients receiving Dyrenium (triamterene,
F). Rarely, leukopenia, thrombocytopenia,
nulocytosis, and aplastic anemia have been
rted with the thiazides. Watch for signs of
ending coma in acutely ill cirrhotics. Thia-
s are reported to cross the placental barrier
appear in breast milk. This may result in
or neonatal hyperbilirubinemia, thrombo-
penia, altered carbohydrate metabolism
possibly other adverse reactions that have
rrered in the adult. When used during
nancy or in women who might bear
ren, weigh potential benefits against
ible hazards to fetus.

cautions: Do periodic serum electrolyte and
N determinations. Do periodic hematologic
ies in cirrhotics with splenomegaly. Anti-
ertensive effects may be enhanced in post-
pathectomy patients. The following may
ur: hyperuricemia and gout, reversible
ogen retention, decreasing alkali reserve
possible metabolic acidosis, hypergly-
ia and glycosuria (diabetic insulin require-
ts may be altered), digitalis intoxication (in
okalemia). Use cautiously in surgical pa-
ts. Concomitant use with antihypertensive
nts may result in an additive hypotensive
ct.

erse Reactions: Muscle cramps, weakness,
iness, headache, dry mouth; anaphylaxis;
t, urticaria, photosensitivity, purpura, other
matological conditions; nausea and vomiting
y indicate electrolyte imbalance), diarrhea,
stipation, other gastrointestinal disturbances,
ely, necrotizing vasculitis, paresthesias,
us, pancreatitis, and xanthopsia have
urred with thiazides alone.

plied: Bottles of 100 capsules; in Single
Packages of 100 (intended for institutional
only).

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**Neither inconvenient potassium supplements
nor special K⁺ rich diets needed as a rule.
Just 'Dyazide' once or twice daily for maintenance.**



Two prime reasons patients drop out of hypertensive therapy are (1) the patient failed to understand directions, and (2) the regimen was overly complicated. Dosage is simple with 'Dyazide', easily understood, once or twice daily, depending on response. There's no need to complicate the regimen with potassium supplements or unwieldy potassium-rich diets.

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PREMARIN (Conjugated Estrogens
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Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications for use as follows:

Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus. **"Probably" effective:** For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding. **Warnings:** Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism).

If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.

Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens

should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.

Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:

nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash

hepatic cutaneous porphyria becoming manifest
Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (e.g. osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.

How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.)

No. 865—Each *purple* tablet contains 2.5 mg., in bottles of 100 and 1,000.

No. 866—Each *yellow* tablet contains 1.25 mg., in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 867—Each *red* tablet contains 0.625 mg., in bottles of 100 and 1,000.

No. 868—Each *green* tablet contains 0.3 mg., in bottles of 100 and 1,000.

7352

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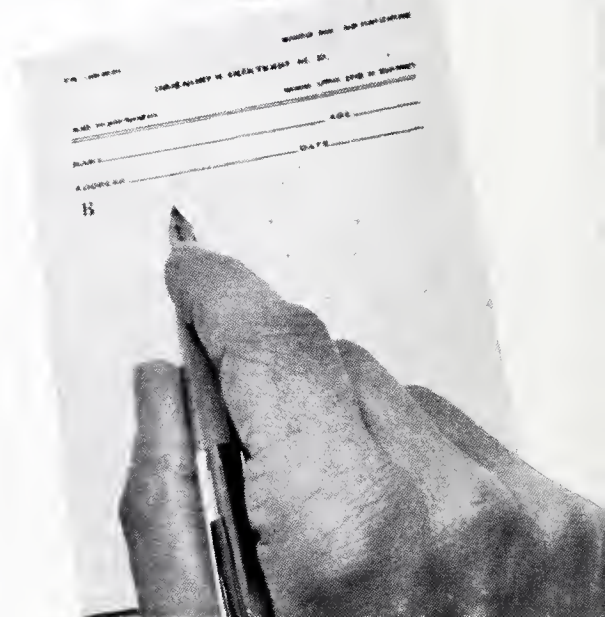
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Bioequivalence



APRIL, 1975
VOL. 34, NO. 4

Hawaii Medical Journal

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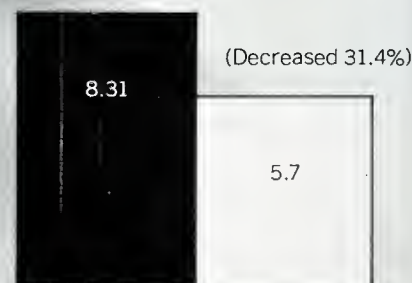


Would sleep with fewer nighttime awakenings benefit your patients with insomnia?

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...can be obtained with Dalmane (flurazepam HCl). As shown below, Dalmane significantly reduces nighttime awakenings:¹⁻⁴

Average Number of Nighttime Awakenings¹⁻⁴
(Four Geographically Separated Sleep Research Laboratory Clinical Studies, 16 Subjects)



3 placebo baseline nights

7 Dalmane (flurazepam HCl) 30 mg nights

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Dalmane (flurazepam HCl) is relatively safe, seldom causes morning "hang-over"...

...and is well tolerated. The usual adult dosage is 30 mg *h.s.*, but with elderly and debilitated patients, limit the initial dose to 15 mg to preclude oversedation, dizziness or ataxia. Evaluation of possible risks is advised before prescribing.

REFERENCES:

1. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
2. Frost JD Jr: A system for automatically analyzing sleep. Scientific exhibit at the 44th annual Clinical Convention of the American Medical Association, Boston, Nov 29-Dec 2, 1970; and at the 42nd annual scientific meeting of the Aerospace Medical Association, Houston, Apr 26-29, 1971
3. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
4. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
5. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly

or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

Depend on highly predictable results with

Dalmane[®] (flurazepam HCl)

One 30-mg capsule *h.s.* — usual adult dosage (15 mg may suffice in some patients).

One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

specifically indicated for insomnia

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- sleep with fewer nighttime awakenings
- sleep within 17 minutes, on average
- sleep for 7 to 8 hours, on average, with a single *h.s.* dose.



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Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities.

Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Anti-hypertensive effects may be enhanced in post-sympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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Each capsule contains 50 mg. of Dyrenium[®] (brand of triamterene) and 25 mg. of hydrochlorothiazide.

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Two prime reasons patients drop out of hypertensive therapy are (1) the patient failed to understand directions, and (2) the regimen was overly complicated. Dosage is simple with 'Dyazide', easily understood, once or twice daily, depending on response. There's no need to complicate the regimen with potassium supplements or unwieldy potassium-rich diets.

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Bioequivalence

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the weight of scientific opinion:

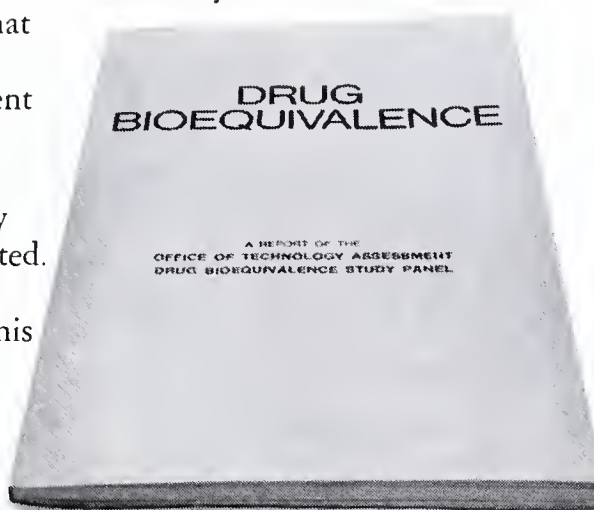
If the pharmacist substituted a chemically equivalent drug for the one you have specified for your patient—could you be certain of that product's safety and effectiveness simply because the chemical content was the same?

Definitely not, unless bioequivalence tests and other quality assurance checks had been conducted. The pharmaceutical industry and many scientists have maintained this position for years, but others have questioned it. Now the Office of Technology Assessment of the Congress of the United States has reported on the issue in its Drug Bioequivalence Study.*

Here are a few definitive statements in the O.T.A. report:

"...the problem of bioequivalence in chemically equivalent products is a real one. Since the studies in which lack of bioequivalence was demonstrated involved marketed products that met current compendial standards, these documented instances constitute unequivocal evidence that neither the present standards for testing the finished product nor the specifications for materials, manufacturing process, and controls are adequate to ensure

that ostensibly equivalent drug products are, in fact, equivalent in bioavailability.



"While these therapeutic failures resulting from problems of bioavailability were recognized and well documented, it is entirely possible that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

The Pharmaceutical Manufacturers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical products, subject to new drug procedures, to document:

(a) chemical equivalence; and

(b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or (c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual inspections and certification thereafter, and strict adherence to FDA regulations on good manufacturing practices.

The overall quality of the United States drug supply is excellent. But only a total quality assurance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription...



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

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Pro-Banthine is considered adjunctive in total peptic ulcer therapy that may include diet, conventional antacids, bed rest, and other supportive measures.

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a good
option
in peptic
ulcer



Pro-Banthine®

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Indications: Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control.

For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

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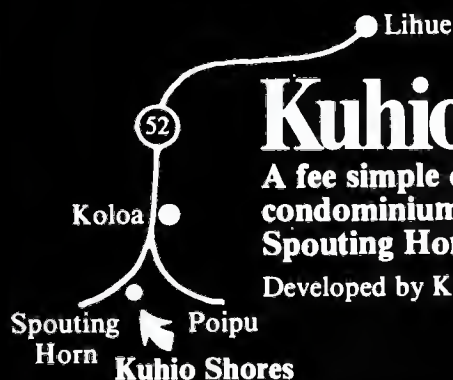
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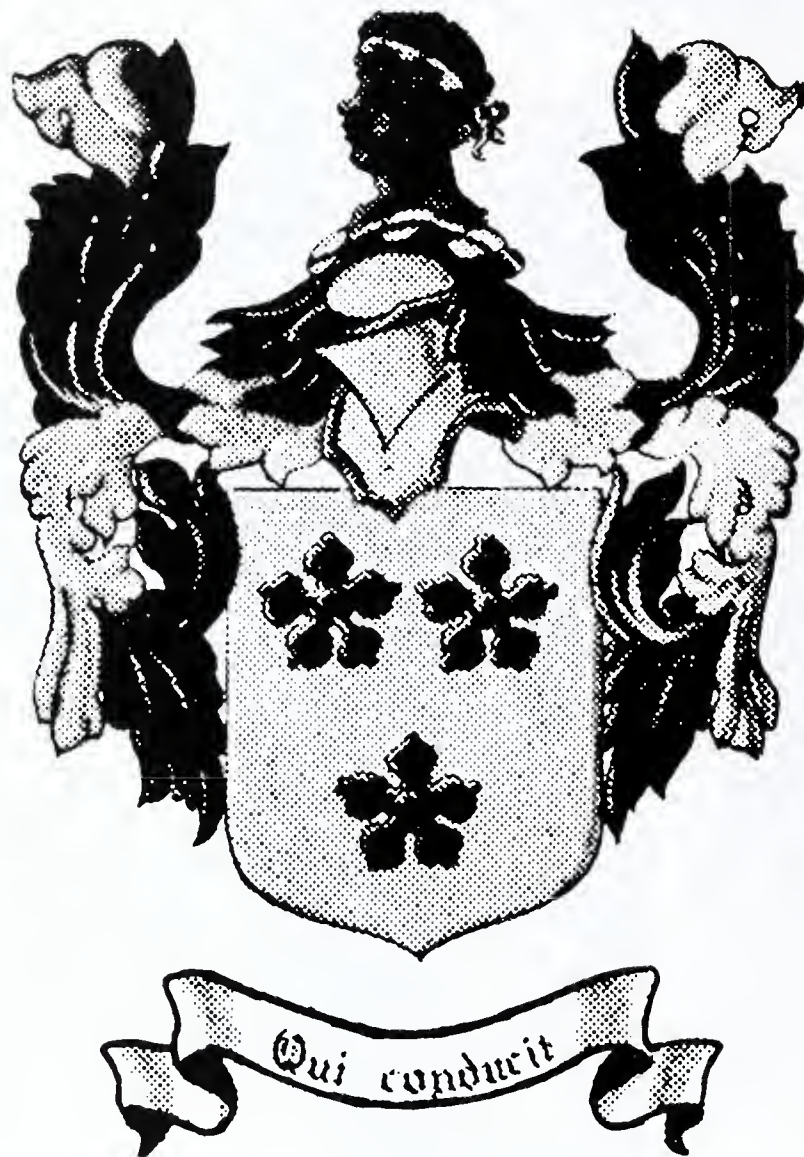
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Hemodynamics And Prognosis In Heart Block

HARRY M. THOMAS, JR., M.D., MAJ, MC, *Honolulu*

For purposes of this article the degrees of atrio-ventricular (A-V) block will be defined as follows:

First degree A-V block is defined by most as a PR interval of 0.21 sec or more without any dropped beats, or failure of atrial impulses to capture the ventricles.

Second degree A-V block requires the presence of atrial beats which are conducted and those which are not conducted (dropped beats) to the ventricles:

1) Wenckebach type (Mobitz I)—progressive prolongation of the PR interval, eventually resulting in a dropped beat.

2) Mobitz II—dropped beats occur but the PR interval of all conducted beats is constant.

3) High grade A-V block—occasional atrial beats are conducted to the ventricles.

Third degree A-V block or complete heart block (CHB)—total lack of A-V conduction.

An important distinction is to be made between A-V dissociation and A-V block. The term A-V dissociation can be used whenever atria and ventricles are concurrently responding to separate pacemakers^{1,2}. A good example is ventricular tachycardia without retrograde conduction. A-V block may or may not accompany A-V dissociation.

This article will discuss the hemodynamics and prognosis of complete heart block only. Lesser degrees of A-V block will not be included.

The etiologies of complete heart block are multiple^{3,5} and will not be discussed here except as they pertain to hemodynamics and prognosis. Instead electrical and the clinical consequences of CHB will be discussed.

Electrical Consequences of Complete Block

The heart rate is governed by the site in the heart with the fastest rate of spontaneous discharge. Normally this site, or natural pacemaker, is the SA node. If the dominant pacemaker fails, or conduction of electrical impulse is blocked, other pacemaker sites "escape" and assume control of the heart rate. If the escape pacemaker is in the area of the A-V junction, a rhythm is established which has a narrow QRS, a relatively fast rate of discharge (40-60/minute), and is responsive in part to autonomic control. If a lower idioventricular pacemaker assumes control, the rate of discharge is much slower (10-30/minute), there is a widened QRS, and the rate is unresponsive or poorly responsive to autonomic control.

If there is sudden onset of heart block, there is often an asystolic period of 10-90 seconds before an escape rhythm occurs. This has been termed the pre-automatic pause³. On occasion no escape occurs and ventricular asystole results. Ventricular asystole can also occur with an existing junctional or idioventricular rhythm^{3,5,6}.

PVC's are often associated with any of these bradycardic escape rhythms. These PVC's can trigger ventricular tachycardia and fibrillation^{3,6-9}.

Clinical Consequences of Complete Block

Hemodynamics in CHB—Determinants

Here is one simple formula for calculation of cardiac output (and ultimately tissue perfusion):

Cardiac Output (CO) = Heart Rate (HR) x Stroke Volume (SV)

With exercise, normals are able to increase their cardiac output by 300-400% and trained athletes by 500-600%¹. Of the two determinants of CO in the above equation, HR is the most

From the Cardiology Service,
Tripler Army Medical Center, Honolulu, Hawaii
Address reprint requests to Dr. Thomas,
at Box 157, TAMC, Honolulu, HI 96438
Presented at the 1974 Pacemakers Symposium,
Honolulu, Hawaii, January 18, 1974
Accepted for publication January 20, 1975

variable and thus the more important in the ability of the heart to increase its output. This introduces the concept of "Cardiac Reserve"—or the increase in CO the heart can generate in response to increase in demand.

In CHB, when the heart has no ability to significantly increase the HR, the reserve of the heart is diminished and any increase in CO is dependent on elevation in SV¹¹. In some cases of congenital CHB, the heart rate can increase somewhat⁵. These patients have a higher cardiac reserve; however, congenital CHB accounts for only about 7% of cases of CHB. Thus the great majority of patients with CHB have marked limitation of cardiac reserve.

Animal studies and studies of humans with CHB and otherwise normal hearts have provided information on hemodynamics of CHB without associated heart disease.

Forsythe et al surgically created CHB in monkeys and measured CO and blood flow to various body regions over a six-hour period¹². Fifteen minutes after the induction of CHB, the monkeys were noted to have a decrease in mean aortic pressure, cardiac output, and stroke volume. At this point, flow to all organs and tissues was decreased, but there was preferential perfusion of the heart, brain, adrenals, liver, and skull at the expense of skeletal muscle, kidney, skin, spleen, and pancreas. At two hours, coronary flow was decreased 30%, but a larger percentage of the total cardiac output was directed to the coronaries. At six hours, the cardiac output had returned almost to normal, due to a compensatory increase in blood volume and SV. Thus, in monkeys without coronary artery disease, acute heart block reduces blood pressure and cardiac output; blood flow is redistributed to vital organs by sympathetic reflexes until slower acting compensatory mechanisms can return the cardiac output towards normal.

Several hemodynamic studies have been performed in chronic CHB. Dogs with chronic heart block over several months have low normal CO with high SV¹³. In man with chronic CHB, the slow rate allows a longer diastolic filling period and thus an increase in SV⁵. Catheterization studies by Levinson¹⁴ and others^{13, 15, 16} of patients with CHB show low normal or decreased CO, elevated SV, increased right atrial pressure, increased systolic pressure in the right ventricle, pulmonary artery, left ventricle, and aorta, increased pulmonary artery wedge pressure (left ventricular filling pressure), increase in left ventricular end-diastolic pressure and end-diastolic volume, and increase in the pulmonary and systemic resistance.

Johansson¹⁷ found that patients with CHB have an exaggerated fall in CO with the orthostatic stress (26% decreased CO versus 20% in normal), and have a marked reduction in functional capacity to supine exercise as compared

to age-matched controls. Some patients with CHB were able to increase CO with exercise. Those who could not were regarded as having serious myocardial disease. Patients with CHB have a decreased ability to excrete a sodium load, even in the absence of overt congestive heart failure⁵.

Studies of regional blood flow in patients with CHB have shown that most have decreased coronary¹⁸, cerebral^{4, 19, 20}, and renal blood flow^{4, 15, 21}. Stack et al showed that older patients with CHB have decrease in oxygen consumption but increase in oxygen utilization allows them to compensate for decreased CO¹⁵.

A problem that must be noted is that all hemodynamic studies in humans are compromised by the fact that many of the patients have serious myocardial, cerebral, and renal disease, and many of the hemodynamic studies in humans are consistent with congestive heart failure. Through a decrease in oxygen consumption and an increase in oxygen utilization, many of these patients can compensate. Any increase in cardiac demand may precipitate overt cardiac decompensation.

Drugs which stimulate increase in cardiac rate and performance, such as isopropyl norepinephrine¹⁵ and norepinephrine¹¹, and cardiac pacing¹¹ in CHB will cause up to a 50% increase in cardiac output. Regional blood flow, such as coronary¹⁸ and renal blood flow¹⁵ increase with pacing. Cerebral circulation increases slowly after institution of pacing, and pacing has been shown to reverse minor EEG abnormalities and improve mentation in patients with chronic CHB^{19, 20}. Pacing also increases significantly the cardiac output response to exercise in patients with chronic CHB¹⁶, decreases the severity of any overt CHF, and lowers all of the abnormal chamber and vessel pressures at catheterization^{13, 16}. Sequential atrial and ventricular pacing results in even greater hemodynamic improvement¹¹.

Clinical Symptoms in CHB

The exact incidence of complete heart block is impossible to ascertain. It has been estimated that 30,000-40,000 patients in the U.S. develop CHB annually²¹.

The symptoms of CHB can be very few. Heart rates between 30-60 beats per minute do not necessarily produce pain, dyspnea, weakness, or syncope^{4, 5, 8}. Clinical syndromes resulting from complete block can be divided into two types:

1. Syndromes resulting from a persistent slow heart rate:
 - a. Congestive heart failure.
 - b. Renal insufficiency.
 - c. Encephalopathy.

Forty per cent with CHB have overt congestive heart failure⁸. Patients with severe conges-

tive failure, renal insufficiency and CHB usually have severe underlying cardiac disease. Usually the congestive failure has its onset before or at the onset of CHB but sometimes afterwards. The heart failure and renal failure often improve with pacing.

A syndrome of severe encephalopathy characterized by weakness, prostration, and even a state of semiconsciousness may result when the heart continues to beat regularly but very slowly (15-20/minute)⁸. Interestingly, angina pectoris is uncommon in patients with CHB (increased diastolic coronary filling)⁴.

- 2. Episodic paroxysmal circulatory failure resulting from sudden change in cardiac rhythm—the Stokes-Adams syndrome.

Stokes-Adams Syndrome

Stokes-Adams syndrome is defined as transient attacks of cerebral ischemia due to a sudden change in the cardiac rate, rhythm, or conduction resulting in a reduced cardiac output. Another term used is “arrhythmia-induced syncope”³.

This syndrome was described by Adams in 1828 and in 1854 by Stokes. However, Morgagni had described it in 1769 and prior to him, Gerbezius. If we include all of the describers up to Stokes sequentially, we would use the eponym, Gerbezius-Morgagni-Spens-Burnett-Adams-Mayo-Gibson-Holberton-Worthington-Stokes syndrome!

The underlying cardiac mechanism is an arrhythmia which temporarily halts or diminishes cerebral blood flow:

Arrhythmias producing the syndrome include³:

- 1) sudden interruption of A-V conduction producing transient asystole;
- 2) atrial standstill with failure of junctional escape;
- 3) asystole in the presence of established block;
- 4) paroxysmal ventricular tachycardia and fibrillation with established complete block (various authors feel tachyarrhythmias are responsible for 10-65% of Stokes-Adams episodes^{3, 6, 8, 9});
- 5) Paroxysmal tachyarrhythmia with normal A-V conduction;
- 6) supraventricular tachyarrhythmias;
- 7) combined forms.

Symptoms depend on: 1) duration of interruption of cerebral blood flow; and 2) underlying cerebrovascular disease⁶:

- 3-5 seconds—symptoms of cerebral vascular insufficiency—dizziness and distress.
- 5-10 seconds—syncope ± seizures
- 30-90 seconds—death

The incidence of Stokes-Adams episodes in patients with CHB is placed at between 35-61%, depending on the individual series^{3, 8, 22}. The higher numbers are reported from a group of hospitalized patients⁸. It was the presenting complaint in 21% of patients found to have CHB, whereas many patients have CHB months-years before the first episode. It is rare for patients to have only one episode; the frequency of attacks varies widely from every few minutes to years apart.

Prognosis of CHB

The patient with complete heart block lives constantly with the threat of sudden cessation of an effective cardiac output from either ventricular asystole or a ventricular arrhythmia.

Studies of large series of patients with CHB have confirmed that these people have a dismal prognosis. The mortality of patients with CHB and Stokes-Adams attacks is approximately 50% per year^{3, 8, 21, 22}. This mortality varies with the age of the patient and somewhat with the etiology of the heart block²² (Figure 1). Unfor-

FIG. 1—One year survival of patients after onset of complete heart block dependent on the etiology of heart disease resulting in the heart block. Data modified from Johansson²².

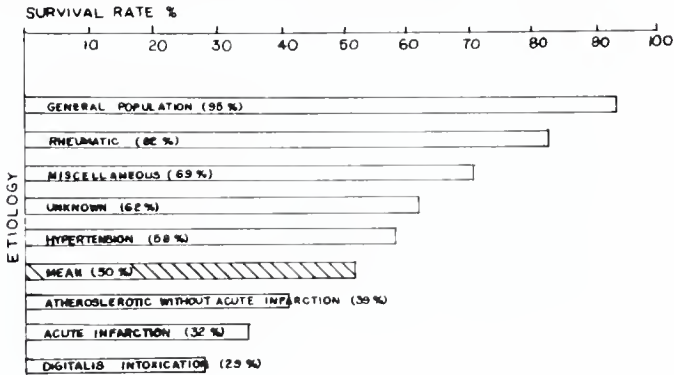
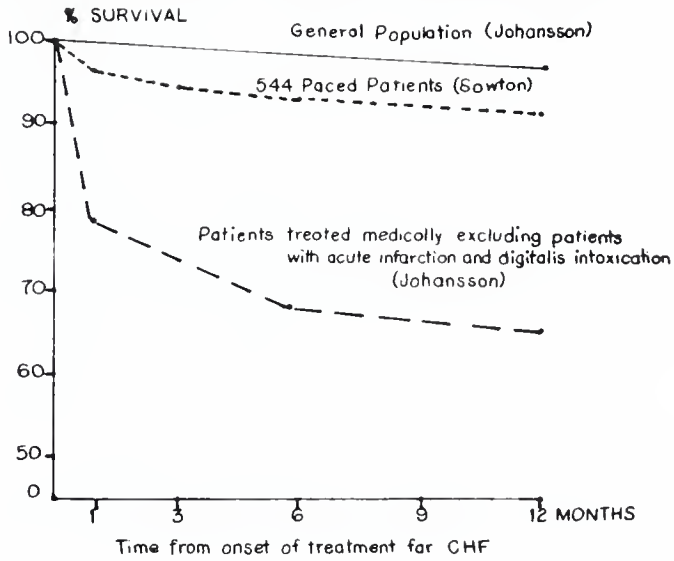


FIG. 2—One year survival in the general population, patients with complete heart block treated with artificial cardiac pacing, and patients with complete heart block treated medically.



unately there are no good clinical prognostic guidelines as to which patients will do well with their CHB. Those patients with atherosclerotic heart disease, congestive heart failure, and Stokes-Adams attacks do very poorly.

Figure 2 shows the mortality of CHB treated medically compared to four different series of patients with CHB treated with pacemaker implantation. With pacing, survival approximates that of an age-matched general population sample. For this reason, the indication for perma-

nent pacemaker insertion in CHB should be very generous.

Acknowledgments

I am indebted to Dr. Edward Kamin, (COL, M.C., U.S.A., Chief of Medicine), and Dr. Michael Dougherty, (MAJ, M.C., U.S.A., Cardiology Service), for their critical review, and to Ms. Sophie Cuban for assistance.

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An Open Letter to JCAH

March 24, 1975

John D. Porterfield, M.D.
Director, Joint Commission on the Accreditation of
Hospitals
875 North Michigan Avenue
Chicago, Illinois 60611

Dear Dr. Porterfield:

I am nearly 36 years out of medical school and well established in the private practice of medicine as a Family Practitioner in a suburban community some 15 miles out of the center of Honolulu. I have been in this location for 19 years; my father practiced here 50 years ago.

Two or three years ago my partner and I gave up major surgery in the hospitals because we found the increase in malpractice premiums greater than the income from that hazardous endeavor. We now do office practice that includes minor surgery; we still deliver babies, and we hospitalize our own patients.

"Our" hospital is Castle Memorial Hospital, situated on the Windward side of Oahu across the mountains from Honolulu. It is 5 miles away from the office and it serves an ever-growing area in which 70-80,000 people reside.

The hospital has 101 acute care beds and a 34-bed Skilled Nursing Facility. It is administered most capably by the Seventh Day Adventist Church, which also supports it. It has a Medical/Dental Staff of some 100 physicians, dentists, osteopaths and podiatrists (Yes, we think the latter are co-practitioners!); of these, about 40 are "Active". We are a congenial staff and we work well together. There is a good mixture of specialists and generalists such that neither group can overpower the other. Included is a large staff of Emergency Room physicians in a clinical department of their own; they cover the E.R. 24-hours a day, 7-days a week.

Many of us oldtimers worked hard for over ten years trying to get this hospital built in our community. It opened its doors in January, 1963, and we have been very proud of the way the hospital has served the community through its various internal entities. Our pride is reflected in the way the community has appreciated the presence of the hospital and its many services.

Your inspecting teams know all this, and more. I am not certain that you yourself, or the members of the Commission do; hence the above introduction has been given in

some detail. I need to tell you one more thing before getting through the integument and into the operative field: I myself have served as Chief-of-Staff of Castle Hospital. I have *always* been an "active" member of its M/D Staff. I am currently Chief of its Family Practice Department, again, and I have been chairman of its By-Laws Committee for several years in succession lately.

Now let's get down to the reason for this letter.

I am angered, resentful, disgusted, amazed, and appalled at what came out of the JCAH inspection conducted by psychiatrist Jones and administrator Moore, in one day, on the day before Thanksgiving, November 27, 1974. I am speaking of the "award" of "accreditation for one year only". I am writing as a vitally concerned member of our M/D Staff, but not for it. I write to express a personal opinion, and to explain to you, who has been on the Commission for almost as long as I have been in practice, why I feel as I do. Hopefully, you will consider what I have to say seriously, deriving from it constructive criticism in whatever form you can find it.

The gist of the criticism by the inspecting team of the JCAH thrown at us consists of:

- 1) The presumption of wrongdoing on the part of the M/D Staff;
- 2) The presumption of doubt as to the quality of medical care dispensed within the hospital's jurisdiction;
- 3) The presumption, if minutes are not voluminous, lengthy discussion in committees and in departments not minutely documented, and overall statistical studies not done continuously, that therefore no M/D staffwork was done and that the quality of care was not evaluated;
- 4) The presumption that each of us on the M/D Staff *must* snoop and spy on our colleagues—that we do not, in fact, do it at all!
- 5) And, therefore, we should be only grudgingly accredited as a hospital because we have failed collectively to conform to either the mandates of the government (DHEW), or to its new serving boy: The JCAH.

First off, let me say that I have always heretofore respected the JCAH for being "one of us—on our side—as an advisor, or mentor, or even a wise and strict parent". Am I now to see it as a punitive policeman? An institution that has been scared out of its wits by an all-powerful, invasive and autocratic government? I always thought the function of the JCAH was to provide guidelines, rather than mandate rules and regulations! I never thought the JCAH would become quasi-governmental in its dealings with us at the grass-roots level, we who are active in the independent and autonomous M/D staffs in the hospitals of this country.

The JCAH—just like the government—has come to ignore completely, or has completely set aside the basis of medical practice: THE CARE OF THE PATIENT, IN SICKNESS AND IN HEALTH, IS THE PREROGATIVE AND THE RESPONSIBILITY OF THE INDIVIDUAL PRACTITIONER! The hospital does not—should not—practice medicine. Neither does the M/D Staff as a whole do so. Only the individual practitioner practices medicine, or dentistry, or podiatry, etc. If this premise is granted (how can it be denied?), then the regulatory bodies, and even the advisory bodies such as the JCAH, should realize that any "busy-work" must take a very secondary role.

The busy physician who sees a lot of patients (popularity usually signifies a good reputation) has a primary obligation to provide good medical care to them. Of course, he should document his work, as any good scientist must, as he goes along, or as soon thereafter as the exigencies of time and no loss of accuracy or honesty permit. However, that busy and reputable physician should not have to sacrifice care of the patient simply to satisfy the requirements of documentation per se, and much less so for the purpose of busywork in staff administration, or in spying on his equally reputable colleagues, or in doing quite useless statistical reviews. The latter, in particular, is a gross imposition upon an already overworked practitioner, and is a

direct threat to the well-being of patients who must wait while he does this additional and unremunerated "work".

I will not wear out your patience by delineating each item of criticism leveled at Castle Hospital by your inspection team, and by replying specifically. Instead, I would like to present to you a "bill of rights" which I would hope my M/D Staff would endorse, when I present it to them also, as well as to my colleagues in practice. Please consider the following seriously:

- (1) The primary duty and obligation of each member of a hospital's M/D Staff is to serve his/her admitted patient well and to that patient's full satisfaction.
- (2) The staff member should document what he does as he goes along, in a scientific, accurate and honest fashion, remembering that clarity of communication will aid those who must work with him as a team, and those who might have to follow—all in the best interest of the patient.
- (3) The staff member is accepted on the M/D Staff on the basis of his credentials—his training, his past experience, and his demonstrated competence; the latter may well require proof through continued observation in a probationary period.
- (4) Once accepted on the staff and granted privileges to practice commensurate with criteria delineated by his peers, the staff member is presumed to be capable, skillful and honest UNLESS, through the several audit mechanisms set up by M/D Staff organization, there is reason to believe otherwise.
- (5) The burden of proof of the member's wrong-doing rests with his peers; the member will have his rights protected by due process.
- (6) The M/D staff member has an obligation to serve in an administrative capacity for the betterment of the institution as a whole, but NOT at the expense of taking care of his own patients.
- (7) The member of the M/D Staff can expect to serve his organization ONLY as a volunteer; should his services be mandated by anyone, it should be on a contractual basis, with fair and just remuneration prearranged.
- (8) The M/D Staff as a whole does NOT practice medicine.
- (9) The M/D Staff as a whole can NOT be obliged to do extra work, except as its members individually volunteer to work, or contract to do so.
- (10) The accreditation of the hospital and its M/D Staff should be based primarily on the quality of medical care dispensed to patients (outcome) by the individual practitioners involved, and NOT on the basis of unnecessary and irrelevant and time-wasting adherence to rules and regs.
- (11) Peer review must be recognized for what it has been for as long as physicians have been practicing medicine—a tradition—and for what it now is more than ever before: Continuing Medical Education, rather than a method of punishment and self-service.
- (12) Cost control is something we are well aware of; its significance is now the greater as Third Parties are more involved than ever before on behalf of the patient. Its implementation is not to be borne by the physician alone; cost control must be built into the contract between patient and Third Parties, so that each element has a stake in its success. Cost control must NOT interfere with quality of health care.

What the JCAH has succeeded in doing by its last accreditation of Castle Hospital is a crime against the community.

The JCAH has thrown the administration into a tizzy of fear—because the several fiduciary agencies might see fit to curtail or withhold payment retro-actively, as they have done in the past.

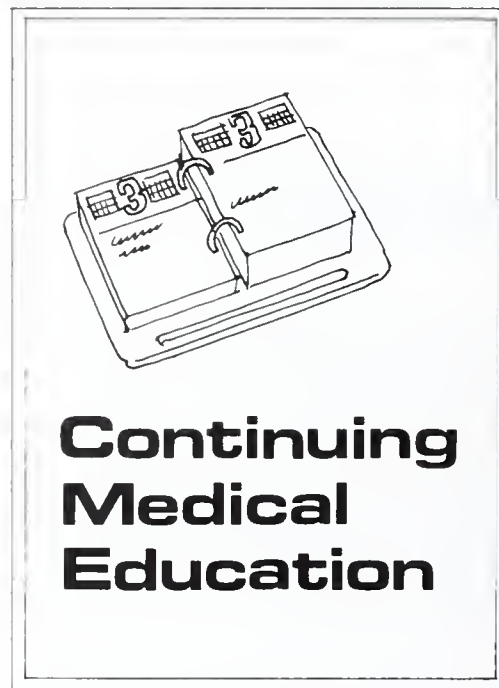
The JCAH has thrown the M/D Staff into an uproar of cross-purposes. There now exists an air of frustration and anger—certainly not an attitude of penitence and let's-do-better! Hours are being spent AWAY FROM PATIENT CARE

—in discussions and wranglings and time-wasting meetings. By-Laws are to be rewritten—to cover every eventuality on paper; their writing may have no relation to actuality, but the next inspection team will be blinded by words and paper.

Please, Sir, let's have done with this! If the government is going to insist on this approach, let the government do the inspecting. Let not so ancient and honorable an institution as the JCAH so prostrate itself!

Sincerely yours,

J.I. Frederick Reppun, M.D.



ELIZABETH K. ANDERSON, M.D.

Continuing Medical Education

Institution and Hospital Accreditation Activities:

Kuakini Hospital will be surveyed on April 22, 1975 for accreditation by an HMA team consisting of Drs. Edgar Ho (Chairman), Richard Tesoro, and Leonard Jacobs.

Calendar of Accredited Events

(One unit AMA credit for CME for one hour of program excluding "breaks")

LOCAL:

Kauaikeolani Children's Hospital

May 3-7 Visiting Consultant on adolescent obesity problems; Dr. Ruth L. Huenemann from University of California at Berkeley.

Contact Department of Pediatrics at Children's Hospital for further details. Phone 537-4818.

Special Events:

April 23-24 *Perinatal Care for the Non-Specialist* at Kaupolani Hospital Medical Education Conference Room; sponsored by Hawaii Sections of the American College of OB-GYN and American Association of Family Practice; 7:00-10:00 a.m.; 5 units Category I AMA Credit/AAFP Credit; physicians and nurses involved in the care of pregnant women are invited; no tuition fee.

April 25 Repeat of seminar listed above at the Maui Beach Hotel, Kahului, Maui, Second Floor Conference Room; 7:00 a.m.-12:30 p.m. (Note: travel and room arrangements to Maui are responsibility of seminar participant.)

Contact: Ralph Hale, M.D., phone 955-6611, ext. 373

May 19-22 *Obstetrics/Endocrinology and Infertility—*
USC at Mauna Kea Beach Hotel, Kamuela
Contact: Phil Manning, M.D., Assoc. Dean
Postgraduate Division
University of Southern California
School of Medicine
2025 Zonal Avenue
Los Angeles, California 90033

June 8-13 Pacific Association of Pediatric Surgeons
Royal Hawaiian Hotel, Honolulu
Contact: Walton K. Shim, M.D.
1481 S. King Street
Honolulu, Hawaii 96814

June 12-17 Pacific Dermatologic Association
Hilton Hawaiian Village, Honolulu
Contact: Robert J. McNamara, M.D.
2828 Telegraph Avenue
Berkeley, California 94705

OUT OF STATE:

AMA Regional CME Programs —

8 Courses offering Category I credit

- 1) Dermatology for non-Dermatologists
- 2) Infectious Diseases and Antibiotics
- 3) Fluid and Electrolyte Balance
- 4) Venereal Disease
- 5) Pulmonary Function and Blood Gases
- 6) Basic and Advanced Support CPR
- 7) Basic ECG
- 8) Human Sexuality
 - a) Minneapolis, Minnesota (July 26-27)
 - b) Williamsburg, Virginia (September 27-28)

For further information, write:
Department of Scientific Assembly
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610

American College of Physicians Courses:

- May 8-10 *Selected Topics in Internal Medicine*
Washington, D.C. Hospital Center
- May 9-10 *Latest Developments in Internal Medicine*
Iowa City, Iowa, University Hospital
- May 14-16 *Clinical Auscultation of Heart*
Georgetown University Medical Center,
Washington, D.C.
- May 15-17 *Latest Developments in Internal Medicine*
Bend, Oregon
- May 15-17 *Respiratory Pathophysiology*
McGill University, Montreal, Canada
- June 2-6 *Hematology and Oncology*
University of Chicago Cancer Research Center,
Chicago, Illinois
- June 23-27 *Advances in Internal Medicine: Horizons and Perspectives*
University of Alberta, Banff, Canada

For further information, contact:

Registrar of Postgraduate Courses
American College of Physicians
4200 Pine Street
Philadelphia, PA 19104

Other:

- May 12-13 *Exercise: Current Concepts in Clinical Cardiopulmonary Disease* Marriott Motor Hotel, Philadelphia, Pennsylvania Sponsored by American College of Chest Physicians, 11 hours credit; \$100 tuition/ACCP members — \$125/non-members
Contact: Bradford W. Claxton, M.Ed.
911 Busse Highway
Park Ridge, Illinois 60068

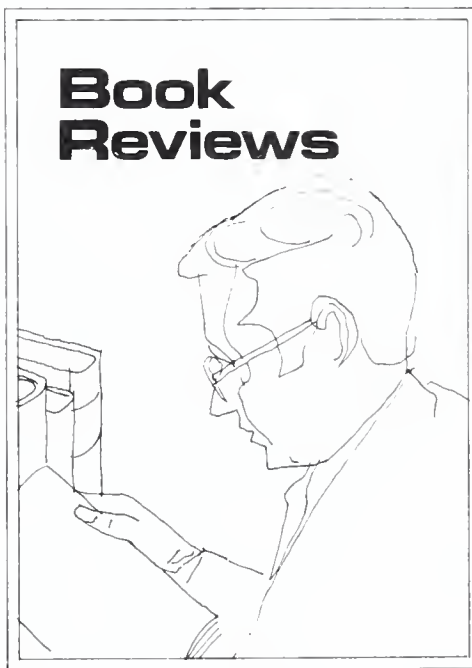
May 22-24 *22nd Annual Meeting of the American College of Sports Medicine*
Marriott Hotel, New Orleans, Louisiana; 15 hours credit
Contact: Gary R. Jenks, Executive Secretary
American College of Sports Medicine
1440 Monroe Street
Madison, Wisconsin 53706

Further listings: For further detailed listings of numerous Category I accredited CME courses taking place in California and in other states, see the CME Bulletin Board at the HMA Office or refer to the JAMA special issue on continuing medical education. Listings of weekly lectures and rounds of *not yet accredited local institutions* (Category 2 credits) will also be posted as they are received.

Coming Soon:

May 12-13 *Accreditation of Continuing Medical Education Programs in Hospitals* Mabel Smyth Building; sponsored by the HMA for hospital medical education and evaluation teams. Guest faculty from California Medical Association will include Samuel Sherman M.D., Woodbury Perkins, M.D., and James Thorpe, M.D. Registration materials will be mailed to each hospital.
Contact: HMA Office of CME, 536-7702

June 16-18 *HMA Cancer Seminar*
Further details will follow. Watch this space for announcements.



Hawaii Medical Library News

New Staff Members The Library is pleased to announce the appointments of two librarians to its staff: **Miss Ann Koto** and **Mrs. Ruth Swanson**. Miss Ann Koto is the Library's new Reference Librarian. A recent graduate of the University of Hawaii School of Library Science, Miss Koto previously worked for the Library as a cataloging assistant and later as a Library Technician. Mrs. Ruth Swanson is the Library's new Cataloging and Serials Librarian. She is a recent graduate of Case Western Reserve University School of Library Science, where she took special courses in medical librarianship. Upon graduation she worked as an indexer at the National Library of Medicine for six months. Her husband is a naval officer stationed at Pearl Harbor. We wish both Miss Koto and Miss Swanson with best of luck in their new positions.

Increase in Library Usage by Medical Students During the week of March 18-24, 1975 the Library took a routine head count of the persons who regularly use our facilities. Placing these persons in order by user group, we found the following results:

University of Hawaii Personnel	159
Medical Students	100
Nursing Students	59
Physicians (Library Members)	141
Community Patrons	105
Interns, Residents, Externs	62
Nurses	21
Allied Health Science Students	15
Health Organization Members	7
TOTAL	<u>510</u>

This is the first time that University of Hawaii personnel have replaced physician Library members as the largest

group of Library users. This development reflects the growing use of our facilities by the third and fourth year medical students during their clinical work at Queens Medical Center and other community hospitals.

PSRMLS Library Workshop On March 23-24, 1975 **Mrs. Allison Bunting** and **Mr. Michael Homan**, librarians with the Pacific Southwest Regional Medical Library Service (PSRMLS) centered at the UCLA Biomedical Library, held a highly successful library workshop for 25 Hawaii medical librarians and 16 University of Hawaii School of Library Science students. Audiovisual services were emphasized the first day, with guest talks by **Dr. Ted Bell** of the University of Hawaii School of Public Health and **Mr. Donald Huddleston**, Head of Audiovisual Services at the University of Hawaii Sinclair Library. The second day of the workshop featured lectures on library budgets, plus an afternoon training session for experienced MEDLINE search analysts.

Selected MEDLINE Searches for March 1975

DATE	SEARCH TOPIC	NO. CITATIONS	
		RETRIEVED	REQUESTOR
3/4/75	Carcinoid Tumor of the Lung	25	Wayne S. Limber, M.D. Kaiser Foundation Hospital
3/7/75	Food Hypersensitivity	88	Jean P. Muller, M.D.
		6	Obst.-Gyn. Resident Queens Medical Center
3/10/75	Homologous Transplantation of Teeth	27	Robert Pakarsky, D.D.S. Oral Surgeon U.H. Dept. of Anatomy
3/10/75	Pituitary Gonadotropins, Estrogens, Progesterone and Puerperium	8	Santosh D. Sharma, M.D. U.H. Prof. Obst.-Gyn. Kapiolani Hospital
3/11/75	Food Hypersensitivity	88	Carl W. Lehman, M.D. Straub Clinic
3/11/75	Dual Personality	6	Dr. Shapiro Hawaii State Hospital
3/11/75	EEG and Provocative Epilepsy Tests	23	Alvin Murphy, M.D. Hawaii State Hospital
3/11/75	Psychological Aspects of Ulcerative Colitis	18	Kathy Terada U.H. Nursing Student
3/12/75	Patterns in Injuries in Aviation Accidents	12	Ben Lambiotte, M.D.
3/13/75	Bennett Ventilator	2	Pat Peltier, R.N. American Lung Association
3/13/75	Drowning	173	J. K. Sims, M.D. Emergency Medical Services Queens Medical Center
3/13/75	Salmonella Weltevreden	2	David S. Pratt, M.D. Epidemiologist State Dept. of Health
3/18/75	Pheromones	25	Matthew Brady U.H. Medical Student
3/20/75	Rubella in Pregnancy	210	Roy Nakayama, M.D. Obst.-Gyn. Resident Queens Medical Center
3/20/75	Effect of Education on Diabetic Patient	28	Elizabeth Kirkoo, R.N. Kaiser Foundation Hospital
3/24/75	Intestinal Bypass Procedure for Obesity	26	Ray F. Allen, M.D. Fronk Clinic
3/24/75	Cardiogenic Shock and Intraaortic Balloon Pumping	28	Donelo R. Canete, M.D. Fronk Clinic
3/26/75	CO2 Therapy in Nervous and Mental Disorders	9	Alexander Tribe, M.D. Psychiatric Resident Queens Medical Center
3/27/75	Estrogen and Progesterone Induced Hypertriglyceridemia	39	Craig Kadooka U.H. Medical Student



Kuakini Hospital

The Arthritis Center at Kuakini Hospital welcomes referrals and provides consultations for any problems in the field of rheumatology. The project is federally funded and no assuming of, or transfer of, the care of the private patient is involved. Patients may be referred by calling 537-5242. Dr. Melvin Levin is in charge of the program.

Kauikeolani Children's Hospital

Active hospital staff officers will be elected at the annual quarterly staff meeting on April 25, 1975. Candidates are: Chief of Staff, Ann Barbara Yee, M.D.; Assistant Chief of Staff, Carl Lehman, M.D.; and for Secretary, Jeanette Chang, M.D.; Richard Mitsunaga, M.D., and Roy Niimi, M.D.

Officers will be elected by majority vote at the annual meeting of the Medical Staff. Only members of the Active Medical Staff shall be eligible to vote. Nominations may also be made from the floor at the time of the annual meeting, or be made by petition signed by at least 25 members of the Active Staff and filed with the secretary of the Medical Staff at least 15 days prior to the annual meeting.

St. Francis Hospital

Congratulations are in order to the new *Fellows* of the American College of Physicians, Dr. Charles Ching and Dr. Eugene Wong.

Dr. Robert Jim recently passed his Hematology subspecialty Boards.

A gang of us squeaked by the recertification examination of the American Board of Internal Medicine. We better check with the ACP Governor Bernard Fong, but personally haven't heard of anyone who didn't pass!

Our new SFH Cancer Coordinator is Dr. Thomas Lau, who is also Project Director of the Cancer Rehab Program.

Our University of Hawaii Student Coordinator Dr. Bernard Yim, with Dr. Ronald Perry, received a letter of appreciation from our last group of third year clerks rotating through medicine!

The rotational plan of physicians willing to accept those patients who are initially treated by our ER physicians has been working quite smoothly. Should anyone else wish to volunteer to accept these private (non welfare) patients on a rotational basis, please contact Mrs. Pat Kaneda, ext. 226.

H. H. CHUN, M.D.

Hilo Hospital

The Medical Staff of Hilo Hospital has endorsed the recommendations of the January, 1975 Hilo Hospital Study made by Herman Smith Associates.

The recommendations were that an indepth and detailed feasibility study be conducted to decide which would be best for the community: a state operated or a privately owned, non-profit hospital. Need for a modern acute care facility in Hilo is widely recognized.

A special meeting of the Medical Staff has been arranged to explain how PSRO works and how this will be implemented locally.

M. K. GHOSH, M.D.

Queen's Medical Center

At the March 21, 1975 quarterly staff meeting, new members of the Medical-Dental Staff were announced. Granted staff appointments during the last quarter period were: Dr. Jon Betwee, Psychiatry; Dr. Forrest Brown, Dermatology; Dr. Zita Cruz-Bristol, Internal Medicine; Dr. Timothy Kuberski, Internal Medicine; Dr. Philip Kuo, Pediatrics; Dr. Erlinda Magsalin-Cachola, Internal Medicine; Dr. Douglas Massey, Internal Medicine; Dr. Kerry Monick, Psychiatry; Dr. James Nickel, Pathology; Dr. Ronald Perry, Internal Medicine; Dr. Julia Tsuei Obstetrics/Gynecology, and Dr. Dexter Wong, Dentistry.

Voting by the members of the Active Staff took place at the March meeting on the following amendment to the Constitution and Bylaws:

"The Medical Advisory Committee may waive the requirement for observation during the probationary period for any applicant who has satisfactorily completed his entire residency requirements for Board certification in the residency training programs conducted by this hospital, or in joint residency training programs of which this hospital is a component part, or for any applicant who has served as Chief Resident in the residency training programs conducted by this hospital or in joint residency training programs of which this hospital is a component part."

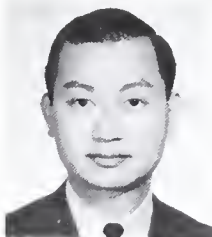
A policy has been developed whereby any employee of The Queen's Medical Center can initiate an "All Male Personnel Code," in the event a patient becomes unmanageable and necessitates the assistance of male personnel.

Pending final approval of the Board of Directors, the eligibility criteria for the Department of Internal Medicine has been changed to read as follows: "The applicant must be certified by the American Board of Internal Medicine, or be eligible for examination by the American Board of Internal Medicine, or have satisfactorily completed an approved residency in Internal Medicine."

1975 members of the Medical Advisory Committee were announced. These are Dr. Benjamin Tom, Chief of Staff; Dr. William Sage, Chief of Staff-Elect; Dr. Arthur Sprague, Chief, Anesthesiology Service; Dr. Richard Mamiya, Chief, Cardiovascular Pulmonary Service; Dr. Lonnie Tiner, Chief, Department of Dentistry; Dr. Robert Clingan, Chief, Dermatology Service; Dr. James Marnie, Chief, Department of General Practice; Dr. Frederick Warshawer, Chief, General Surgery Service; Dr. Edward Chesne, Chief, Department of Internal Medicine; Dr. Douglas Bell II, Associate Chief, Department of Internal Medicine; Dr. Raymond Taniguchi, Chief, Neurology/Neurosurgery Service; Dr. George Goto, Chief, Department of Obstetrics/Gynecology; Dr. Malcolm Ing, Chief, Ophthalmology Service; Dr. John Smith, Chief, Orthopedic Service; Dr. Barton Becker, Chief, Otolaryngology Service; Dr. Drake Will, Chief, Department of Pathology; Dr. Venu Reddy, Chief, Department of Pediatrics; Dr. Frank McDowell, Chief, Plastic Surgery Service; Dr. George Bolian, Chief, Department of Psychiatry; Dr. Grover Liese, Chief, Department of Radiology; Dr. J. Judson McNamara, Chief, Thoracic & Cardiovascular Surgery Service; Dr. James Young, Chief, Urology Service; Dr. Andrew Morgan, Chief, Department of Surgery, and Dr. Charles Judd, Associate Chief, Department of Surgery.



New Members



Szeming Suen, M.D.

823 California Avenue
Wahiawa, Hawaii 96786

SURGERY



Hawaii Academy of Family Physicians' Newsletter

J. I. FREDERICK REPPUN, M.D.

New Members—Ernest L. **BADE** is a new Active member of HAFP—he is with the Hilo Medical Group, joined AAFP Jan 1971 and became ABFP in Oct 1974; Douglas **DOYLE** of Honolulu is listed as an Inactive member HAFP; Louis J. **POLSKIN** is Active and a Fellow, working at Tripler as a civilian; James A. **SILVER** is listed as Inactive, having joined AAFP July 1973 and is a LTC with an APO address.

Transfers Out—Steve **SCHEPPER** has transferred his membership to the California AFP in Redondo Beach.

News of Members—Members will be glad to know that popular Les **VASCONCELLOS** is home recuperating from a rather severe AMI. We all wish him well—quite a few in the HAFP Coronary Club! Diane **DIERICH** is looking for a used EKG machine to purchase. Louis **POLSKIN** didn't

waste much time getting into print: He objected, in Miss Fixit's column, to the decibels from steel plates covering construction holes on Kalakaua Ave; Louis, you'll learn **NOT** to live in Waikiki! Don **FARRELL** has been shifted from Kaiser-Ko'olau to the Waikiki Mainplace and is to head the new "Primary Care" department at Kaiser. Good for you, Don; we're sure you'll make something worthwhile of it for Family Practice and for teaching.

News of Family Practice—Dean Terry **ROGERS** of the UHSM reports that the Manoa Senate on Feb 26 approved a new Department of Family Practice and Community Health. This is a prerequisite for University Administration action. Recruitment is in process for someone to direct setting up the department and a provisionally accredited residency program hopefully to start July 1, 1976. Anyone interested? Bring your patients too!

UHSM—The School of Medicine will be graduating its first class of MD's next month. Nearly all of the graduates were fortunate in receiving their "first match" positions for post-graduate training. Also, Tom **WHELAN** says the UH Integrated Flexible Program matched on first match all 16 positions: Those in it from UHSM are Emmett Aluli, Fred Ching, Vincent Dang, Betty Fyrberg, Chris Lambert, Irwin Lee and John Uohara (none is a member HAFP). UHSM wants to up-date the roster of HAFP members willing to be **PRECEPTORS**. Please notify Frank **TABRAH** at the Dean's office if so.

We Need to Know—which of you belong also, or do **NOT** belong to the **CtyMedSoc-HMA-AMA**? Please let Jean know at 239-8383. Those of you who do **NOT** belong, should be encouraged to subscribe, at least, to the **Hawaii Medical Journal**, still \$8/year, tax deductible. The **NEWSLETTER** is published therein; **CME** courses are listed; editorial & articles of local interest fill its pages.

Old, old Members—According to the record, Varian **SLOAN** is our *Emeritus* member, he having joined AAGP (in California) August 1947; after him come Verne **ADAMS** and Bill **WALSH** in 1948, the latter the senior member of Hawaii origin; Bill **BERGIN**, Wilmot **BOONE** and Walter **OZAWA** are listed as members since 1949; Les **VASCONCELLOS** in 1950 and then a whole host in 1951. When was and who started the Hawaii Chapter?

Compare—your charges with those allowed by the State of New York, as printed in the *New York Family Physician*, Vol. 27, No. 1.

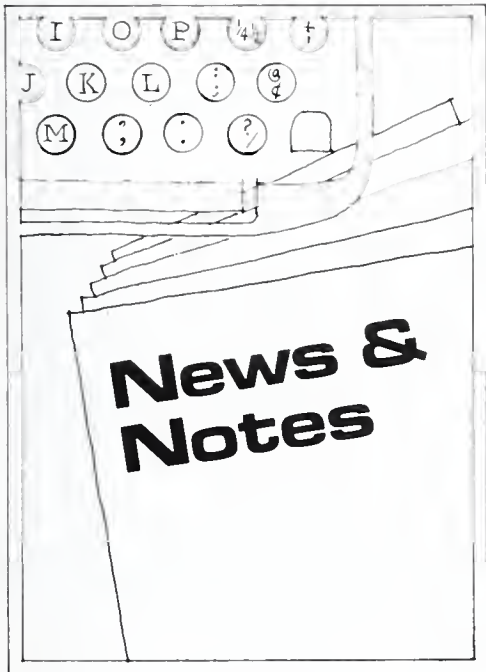
FEES FOR SPECIALISTS IN FAMILY PRACTICE

The State Director of the Budget has approved a fee schedule applicable to office, home and hospital visits by physicians qualified as specialists in family practice. This new fee schedule is effective October 8, 1974.

CODE	PROCEDURES OFFICE VISITS	FEE
	Comprehensive diagnostic history and physical examination, new patient or new illness,	
9660	Child up to and including 16 years	\$12.00
9661	Persons over 16 years	12.50
	Routine office visit, including treatment,	
9662	Child up to and including 16 years	
9663	Persons over 16 years	\$ 7.20
	HOME VISITS	7.50
	Comprehensive diagnostic history and physical examination, new patient or new illness	\$10.00
		12.50
9666	Child up to and including 16 years	\$ 9.00
9667	Persons over 16 years	10.00
	Routine home visit including treatment	5.00
9668	Child up to and including 16 years	
9669	Persons over 16 years	\$10.00
9670	Each additional person at home	12.50

HOSPITAL VISITS

	Initial Visit	\$ 6.00
9671	Child up to and including 16 years	7.50
9672	Persons over 16 years	
	Follow-up visit, including treatment	\$15.00
9673	Child up to and including 16 years	\$ 6.00
9674	Persons over 16 years	7.50
9035	Total new born care in hospital provided by a physician other than a pediatrician, including physical examination of the baby and discussions with the mother during the hospital stay (total fee for minimum 3-day stay)	\$15.00



HENRY N. YOKOYAMA, M.D.

Life in These Parts

We gleaned from Tom Horton's column that **Milton Trager's** wife had donated his almost-new shoes to last year's Temple Emanuel's annual flea market. A surprised woman who bought them found \$350 in traveler's checks and \$10 cash inside...

Disquieting Statistics Column:

A **John Griffin** (program director for the Army on alcohol and drug treatment) claims that there are more than 40,000 alcoholics in Hawaii... And a **Russel Cook** (Chairman of the Oahu Drug Abuse Coalition) says there are 23,000 drug addicts (excluding the alcoholics). Then **Danilo Ponce**, head of children's mental health services for the State Health Department, says that more than 27,000 island children have emotional and mental disorders that require professional help...

In the wake of the housestaff strike in New York hospitals, the Physicians National Housestaff Association predicted that the walkout could spread nationwide... Local hospital officials felt that there was little chance of Island physicians' joining such a nationwide walkout... Queen's chief resident, **Dick Inamine**, said, "Working conditions are considered good and staff doctors are content with their situation and schedules... Nobody's talking about striking." **John Krieger** at Kapiolani felt that while his residents work like dogs at least 85 hours a week, he doubted they would strike... John said, "They're happy with the training component and happy with the salary component..."

Professional Moves

The Year of the Hare is with us, and, true to form, has shown only timid activity thus far in our medical com-

munity...February was a month for family physicians as three new GP's opened their offices...viz **Donald Altfeld** with the Maui Medical Group, **Kenneth Kern** at 1481 So King Street and **Thomas Cahill** at 99-185 Moanalu Road, Aiea. Also in February, psychiatrist **Alvin Murphy** joined **Byron Eliashof** at 1441 Kapiolani Blvd and allergist **Robert Thune** joined the Honolulu Medical Group. In March, internist-nephrologist **Gildo Soriano** joined **Marcellino Vecilla** at 1270 Queen Emma Street...

Incidental Intelligence

Our "Just Checking" man, **Lou Boyd**, says, "The professional fellow least likely to seek counseling when his marriage gets in trouble is the physician. Or so say the scholars who study matrimonial matters. Don't know if it's just coincidence that the medical men get more divorces than do the citizens in other occupations. Our Love and War man reports sadly that doctors rank with bartenders, actors and traveling salesmen on that list of the most divorced."

Claude Caver's Repertoire

A minister, a rabbi and a black man arrive at Heaven's pearly gates...St Peter interviews the minister first. He looks over the record book and finds it near perfect and says, "There is one final test...Spell "God". So the minister spells "G-O-D, God" "That is correct...You may pass." Next, the rabbi is interviewed. Again St Peter reviews the rabbi's record and sees no blemishes. Again he

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says, "As one final test, spell 'God'." So the rabbi correctly spells "G-O-D" "Correct! You may pass on." Then the black man is interviewed. The black man's record is also flawless... St Peter says, "As one final test, spell 'Anthurium'." (A Sammy Davis number)

Community Notes

"**Hoopla! 75,**" a fun-fund raiser for the Hawaii School For Girls, auctioned off about 125 items, including a cosmetic operation by **Leabert Fernandez**...

Neal Winn, HMA Substance Abuse Committee chairman urged the Senate Health Committee to lower the penalties for marijuana. Neal feels that "decriminalizing marijuana would stimulate further medical research... Although there are potential medical complications linked to marijuana abuse, they are not enough to justify present criminal sanctions..."

The U of H School of Public Health will develop a computer health information system with a \$30,920 grant from the Chamber of Commerce. Initially the project will focus on the Windward area and "collect, edit, sort, update, retrieve, summarize and analyze data useful to health service planning, decision making and research." Project director will be **Robert Mytinger**...

Kuakini intern **Robert Thornburgh** went skiing on the slopes of Mauna Kea at the 12,500 foot level in March. He skied over a ledge and found below him, to his dismay, rocks instead of snow... He was evacuated by helicopter and is presently convalescing with left leg in traction...

Benjamin Lambiotte, medical director of Waimano Training School and Hospital, resigned because he was dissatisfied with recent efforts to upgrade the institution and with future plans to improve services for the mentally retarded...

Med School Dean **Terence Rogers** asked the Senate Higher Education Committee for \$9.6 million for the school's operating budget during the 1975-77 biennium and predicted the figure may rise to \$12 million for the 1979-81 biennium. Terry reminded the legislators that the federal government had sunk some \$7 million in the school in the last two years. In the current biennium, the State had put up \$4.5 million of the \$7.7 million operating budget... Terry explained that "what appears to be a significant increase is attributable to the fact that in the past biennium, the school was operating with the benefit of a \$3.3 million, one-time federal grant." Terry also pointed out that the School of Medicine has pulled in additional federal monies for research and training programs equivalent to its operating budget and about 20 per cent of these millions goes directly in the Isle money stream... Later in the month at a public hearing of the House Higher Education Committee, Terry told the legislators, "I won't insult your intelligence by pretending there isn't an uproar about the medical school." Then he and others involved in the U of H School of Medicine "delivered emotional appeals, substantive arguments and just straight bragging in defense of retaining the program."

Miscellany

Oklahoma golfers are familiar with such natural hazards as tornadoes, dust storms and rattlesnakes... Tom and his foursome were trying to sneak in an early round of golf. On the 2nd hole, he just had to take a crap... So he went into the brush and just as he lowered his pants, a waiting rattlesnake bit the head of his penis. Tom wielded his 4-iron and killed the snake, then hollered for help. Doc Jones who was in the next foursome quickly put on a tourniquet and made the usual cruciate incision with a penknife. Then he started to leave for the next hole. Tom pleaded, "But Doc! What now?" "Well, Tom, you have exactly 30 minutes to find out who your friends are..." (As told by **Paul Conduit**)

The same Doc Jones was being pumped at a party by a woman seeking free medical advice... In order to turn her off, he turned to a lawyer and asked aloud if he shouldn't send her a bill. The lawyer assured him that he had every right to bill her. The next day, Doc Jones received the lawyer's bill which read, "For legal services rendered: \$45.00" (As told by HMA secretary **Sue Anzai**)

Health Department

Since the 1960's when national figures on Salmonella were first compiled, Hawaii has consistently led the nation in the rate for salmonellosis. (This has reflected—at least in part—top expertise in casefinding.) The last report shows Hawaii's rate is 7 times greater than the national average of 12.7 per 100,000. The most common type is *Salmonella weltevreden*, which health officials dub as almost unique to Hawaii. It appears to be our geographically specific organism... **Merle G. McPherson**, formerly of Washington, D.C. has been named the chief of State Health Department's maternal and child health branch...

Act 51, a 1974 law, requires that all new students in public and private schools have a physical examination, a tuberculin test or X-ray and immunizations. In early February, nearly 700 of about 25,000 new students had not complied with the law. By March, only 80 students, most of them in the Kahuku and Makaha areas had not been immunized and were thus not allowed to attend school. **David Pradt**, state medical epidemiologist optimistically said, "We think that if the remaining parents understand why we have a law like this, they will make sure their children get the shots."

Under the State law, the pay of any civil servant is not supposed to be higher than 90 per cent of what his supervisor makes. State Personnel Director **Don Botelho** reports that six physicians of the Health Department make more than director **George Yuen**. Tsk! Tsk!

Tom Thorson's Corner

A fella meets a gal at a bar and they get to talking after a few drinks... "Are you married?" he asks. "No, I'm a widow," she says. "I'm sorry... How did your husband die?" "He died from gonorrhea." "But, you don't die from gonorrhea." "You do... if you give it to me!"

A traveling salesman meets a Mormon girl in Salt Lake City. He suggests night clubbing, dancing, movies, etc and she selfrighteously declines all these offers on religious grounds. He finally says, "Well then, how about coming up to my hotel room to see my samples?" She quickly accepts and stays overnight. In the morning, he asks curiously, "How is it you can do this when you can't go night clubbing, or dancing, or to the movies?" She replies, "Well, it goes to show, you can have a lot of fun without hellin' 'round."

Hors De Combat

Our fighting Irishman, **Jack Keenan** representing the Physician's Action Group declared that "Medicaid patients are being victimized by the Medicaid program." Jack feels that even with the new 20 per cent increase in Medicaid fees, the doctors are still below the break even point for Medicaid patients. Jack was critical of the State for ignoring recommendations in the \$200,000 "Greenleigh Report" on Medicaid which could remedy many of the defects in the program. In late March, the Physician's Action Group passed a resolution recommending that all new Medicaid patients be referred to hospital outpatient clinics instead of to private doctors' offices. The resolution also asked for an orderly transfer of current Medicaid patients to clinic type facilities for follow up medical care. The resolution says, "This action is necessary for it is no longer feasible

continued on page 150



H. TOM THORSON

DUES ARE DUE

Don't know about the rest of you, but I'm sick of writing about malpractice insurance. Anyway, there is more, so here it is.

A committee is being formed to explore legal proposals for the purpose of providing a more favorable climate for insurance carriers. Clifford Miyoi, Insurance Commissioner, will preside over the committee made up of representatives of the insurance industry, medical profession, legal lights, hospitals, etc. Dr. Winfred Lee has nominated Drs. Albert Chun-Hoon and Alan Pavel to serve along with Exec. Tom Thorson on the committee. The committee will prepare a legislative package for next session. In the meantime the joint underwriting bill and our committee immunity bill are still alive in the legislature.

In addition HMA is exploring the various possibilities for possible formation of its own insurance plan — either a capital stock venture, a mutual company, or possibly an insurance reciprocal. All of these have built in hazards and require expert management which is very hard to come by. We will keep you informed and if you have any real good ideas — let's hear them.

MEDICARE: The only insurance premium remaining level is the medicare medical insurance premium for the next year. They simply increased the deductible from \$84 to \$92 for hospitalization. Coinsurance also went up from \$21 to \$23 per day for the 61st through 90th day. Provider Reimbursement Review Board appointed by Sec'y Weinberger contains nary a practicing physician. We still complain over the use of the 1964 California RVS for coding.

CHAMPUS no longer pays for arch supports, megavitamins, counseling services by postoral,

marriage, family or child counsellors, treatment for obesity, plastic reconstructive surgery done to help emotional needs, and they never did pay for stop-smoking clinics.

AMA meeting in June in Atlantic City. Deadline date for resolutions is May 15.

AMA suit against HEW over recent regulations should be resolved between the time this is written and the time it is published — we simply can't help the deadline.

Housing for HMA-HCMS and subsidiaries being explored. The situation is becoming acute because of space requirements. With all related organizations now operating we have four different offices in different parts of town totalling about 10,000 sq. ft. with some sixty employees. With the advent of an operating PSRO, space needs will increase markedly. At the present time in addition to the core office in Mabel Smyth we have the Hawaii Tumor Registry, the EMS program, and the Bureau of Medical Economics.

Peer Review problems are closely inter-related with malpractice matters and here are some of the problems —

1. Case involving cancer surgery in which surgeon states family refused to authorize a colostomy — family denies ever discussing the matter with the surgeon. The record is not clear.
2. Patient had ear infection. He was dissatisfied with results of first treatment saw an additional doctor — was unhappy — even went to emergency room for relief of pain with no results. Committee was able to clarify to the patient that time was really the basic element in his pain subsidence. Everybody happy!
3. Patient complained that physician treated her with antibiotics for trichomonas with no results — doctor contended that there was other infection present but his records do not support his statement of other infection. Case remanded by Medical Practice Committee to Peer Review Committee for further review.
4. Patient received hormone shots for about three years and suffered from bleeding and requested physician do a D&C. Patient went to California physician who did a D&C and discovered cancer of the uterus. Successful surgery performed in California. The committee ruled that the standards of the community in Hawaii had not been met.

Doctors available: (With the exception of No. 1, none of these have been checked out)

1. Hiroshi Ikeda, M.D., available for part-time after hours coverage, internist, home phone

531-4775. Available immediately for part-time and after hours coverage and possibly full time if position offered.

2. Philip Van de Carr, M.D. 2219 Berry Road, Rives Junction, Michigan 49277. Seeking temporary license to practice in Hawaii, October 1975 through June 1976. Desires sponsorship of Hawaii physician in Honolulu area. General Practice.
3. Donald J. Ross, M.D. Presently interning at University of Texas. Address 8014 West Hausman, San Antonio, Texas. Wishes temporary employment in emergency room in Hawaii beginning July 1975.
4. Urologist, Robert C. Youngman, M.D., 3515 Harvard, Detroit, Michigan 48224. Finishes residency July 1976 at Henry Ford Hospital. Wishes to practice in Hawaii.
5. Internist seeks position in Hawaii effective August 1, 1975. Ranjit M. Balse, M.D. Address—The Memorial Hospital, Pawtucket, Rhode Island 02860. Has FLEX exam. Will take certifying exam American Board of Internal Medicine in June 1975.

Legislation: This report is being written as the State Legislature enters the final days of the 1975 session. Many of the measures on which we reported in the last *Newsletter* have succumbed to the oftentimes heated debate of committee hearings. Bills which have been filed in committee are those relating to mandatory arbitration and no fault malpractice insurance, mandatory reporting of cancer, generic drug substitution, release of medical records to patients, establishment of a health facilities authority, inclusion of two consumers on the Board of Medical Examiners, payment of usual and customary fees for physician's services under the Medicaid program, and certain amendments to the minor's consent laws. Funds for the Medical School at the University of Hawaii and a statewide School Health Program are included in the budget which will be reworked and finalized by a Senate/House Conference Committee. Funds were also especially noted for free immunization of children by the Department of Health without regard to means. There also appears to be monies for the Breast Cancer Project of the Cancer Society and Pacific Health Research Institute.

Other measures which are close to passage include:

HB 431, HD1, SD1 will provide for the assignment of a third party payment to Medicaid for those receiving public assistance for medical care.

HB 518, SD1 provides immunity for peer review committees and allows them to communicate with other committees and with the Board of Medical Examiners (same as SB 1390).

HB 619, HD1, SD1 allows treatment of minors

with venereal disease and places notification to parents of minors found to be afflicted within the discretion of the physician if the minor is forewarned of this discretion by the physician. Treatment is to include counseling. (Note: this is the *only* amendment to the minor's consent law which has survived debate.)

HB 946, HD1 includes a definition of child abuse which conforms to federal regulations.

HB 990, HD1, SD1 places the administration of the state substance abuse program in the Department of Health with the state advisory commission on drug abuse (created several years ago) to serve as an advisory committee to the Department.

HB 1876 provides for a pooling or joint underwriting arrangement to assure availability of insurance coverage (insurance commissioner can implement *only* if malpractice insurance becomes unavailable in Hawaii).

SB 1628, SD1, HD1 provides for coordination of services for developmentally disabled and creates 25 member Council under Office of the Governor. Several concurrent resolutions (requiring adoption by both the House and Senate) will involve the Association if adopted:

HCR 118 requests the Attorney General to recommend changes in state law and state policy for the purpose of maximizing Medicaid, Medicare, and Supplementary Security Income payments on behalf of individuals eligible for state health programs.

HCR 119 requests that the next budget submitted by the Governor include Medicaid payments for usual and customary charges by physicians, dentists, and other professional health providers.

HCR 122 requests the Department of Health (with HMA assistance) to develop necessary legislation and a plan of action for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for all children.

Senate Resolution 203 was adopted and resolves that no legislation be enacted at this time to require continuing education as a requirement for relicensure of physicians and other licensed health professionals. The resolution calls for the development of programs by the professional organizations including criteria for judging the programs, monitoring attendance, and certifying those who do attend. The Department of Regulatory Agencies is requested to provide support to organizations of health professionals to assist the collection of data "for the future formulation of legislation on continuing education and relicensure of health professionals" and that data collection begin no later than July 1, 1976. (Have you qualified for the *AMA's Physician's Recognition Award*?)

Our "Angels"

Borthwick Mortuary	130
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Herbert K. Horita Realty, Inc. <i>Waialae Iki II'</i>	152
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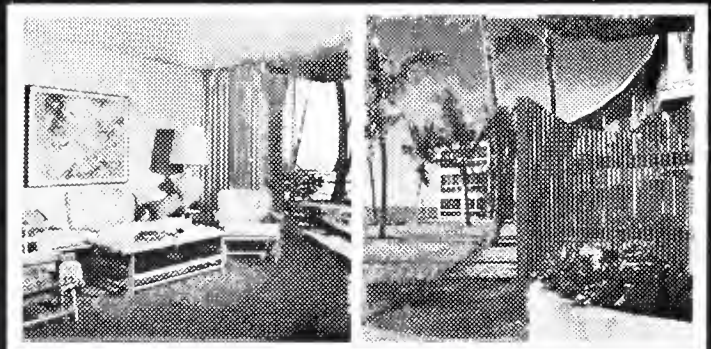
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for physicians and allied health providers to see these patients in their offices." (Wot with malpractice insurance premiums doubling! Not because of the insurance company; it's an order from the National Rating Bureau and the Insurance Commissioner).

Miscellany

Fifi the female gorilla was in heat and the male gorilla imported from a mainland zoo was uninterested... so the zoo keeper in desperation looked high and low and finally found a local man with gorilla-like physiognomy... After much coercing, the prospective stud finally agreed if 3 conditions were met. First, that he doesn't have to kiss her. Second, that Fifi be given a bath and shampoo and plenty of deodorant be used on her. Lastly, that any offspring would be properly baptised Catholic... (As told by our tennis playing architect friend, **Dick Dennis**)

Oncology Conference

A 57-year old woman with vague GU symptoms was found to have a signet ring adenocarcinoma of the bladder dome on cysto and biopsy. Pathologist **Grant Stemmerman** commented, "Signet-ring tumors are most commonly from the stomach, rarely from the intestines, and even more rarely from the bladder... I would still rule out a gastric lesion in this case even though upper GI's and gastroscopy were normal." Internist **Tom Fujiwara** was curious, "How would it spread to the bladder if it was a gastric lesion?" Stemmy explained, "By serosal spread." Radiologist **Don Ikeda** pursued the matter: "Is the Path Department unanimous in the observation that this tumor is gastric in origin?" Stemmy was adamant: "Noooo-o... not even after an autopsy." Stemmy insisted that the primary gastric lesion may be too small to find even at autopsy... He persisted, "The signet-ring tumor from the stomach has a predilection for the GU system... I have 7 cases which had presented with GU symptoms only."

A 69-year old Japanese man with a 2-year history of frequency and nocturia was found to have an elevated acid phosphatase. Cysto and perineal needle biopsy revealed prostatic CA. Bone scan was not done, but the patient had a TUR and orchiectomy... Stemmy announced, "We have 5 cases of prostatic CA in the house now." Immunologist **Ben Gordon** asked, "Shouldn't a bone scan be routine in these cases?" Stemmy pursued the discussion: "The problem is how to stage." Urologist **Bill Shiraki** explained, "Every center is doing it differently... We use staging for treatment... but staging is not as clear cut as it was 7 or 8 years ago... Radiotherapy is used as a curative procedure... The question with estrogen therapy is whether to use before or after symptoms start." Radiotherapist **Carl Boyer** agreed, "Radiotherapy is used for cure, but estrogen works better... Only 5% of cases are amenable to radical surgery, but this results in impotence... Radio-

therapy does control even local metastasis... It is true, there is no clear-cut picture on the mode of treatment." Stemmy added, "35% of all caucasian men over 70 have occult prostatic CA... It's almost a normality." When **Bill Shiraki** said, "Someone recommends routine perineal biopsies," Stemmy bemoaned, "I wouldn't want one... Someone may find it positive."

A 56-year old Japanese man with chronic epigastric complaints and negative UGI series and liver scans 5 months earlier, was admitted for more workup. Gastroscopy revealed poorly differentiated adenocarcinoma extending from the cardio-esophageal junction posteriorly into the pancrea. Surgeon **Bill Morioka** explained, "I would like to avoid a total gastrectomy and pancreatectomy if possible." But the oncologists present demurred from suggesting their poisons... With the situation dismal, moderator **Noboru Oishi** turned to surgeon-immunologist **Eugene Edynak** for help. Eugene started a dialogue: "I speak now as an immunotherapist... We have a pilot program of 4 or 5 patients on BCG after gastrectomy and they are approaching a one year survival. But it's a small series and not statistically significant... I would reduce the tumor volume surgically and try immunotherapy..." Then in a humorous vein added, "The patient certainly is an excellent candidate for any form of therapy." Stemmy said, "I'll be in favor, provided the patient is told beforehand that he will have a rough time... Total gastrectomy and immunotherapy, but not radiotherapy..." Radiotherapist **Ed Quinlan** concurred... Stemmy continued, "The problem will be the esophageal anastomosis... If he is willing to fight, I would go along..." Eugene added the clincher, "But you cannot have more than a gram of tumor tissue left, if immunotherapy is to work." Bill did not look too hopeful...

Miscellany

Two coffee beans were discussing their personal preferences... One bean said, "I'd like to be made instantly." The other bean said, "I prefer the regular grind." (Heard by **Betty Anderson**)

"What's a morner?" "It's like a nooner, but a little sooner..." (Contributed by **Dick Dennis**)

Medical Tidbits

"The incidence of Hepatitis B Antigen is 40 to 50% higher in patients with hepatoma." (**Stemmerman**)

"There is no good medical regimen for ulcerative colitis... Steroids may be useful in massive hemorrhage, but ultimately the patient ends up with a total colectomy and ileostomy" (**Ravitch**... Visiting surgical prof)

"Populations with high risk for ulcerative colitis are also high risk for regional enteritis. The reverse is also true. The Japanese population has very little ulcerative colitis or regional enteritis." (**Stemmerman**) ■

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*Polyunsaturated	3 grams
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*Cholesterol	0 (0. per 100 grams)
Sodium	120 milligrams (865 mg/100 gm)

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Protein	0 (not a significant source of protein)
Carbohydrate	0
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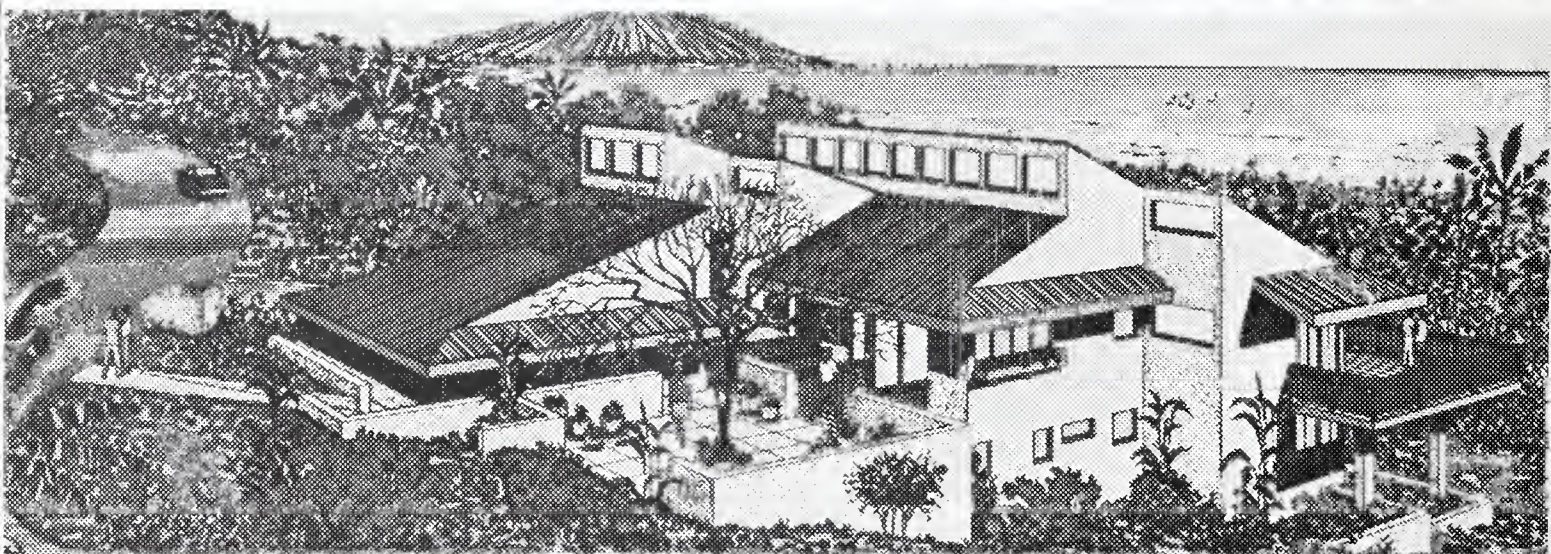
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MAY, 1975
VOL. 34, NO. 5

Hawaii Medical Journal

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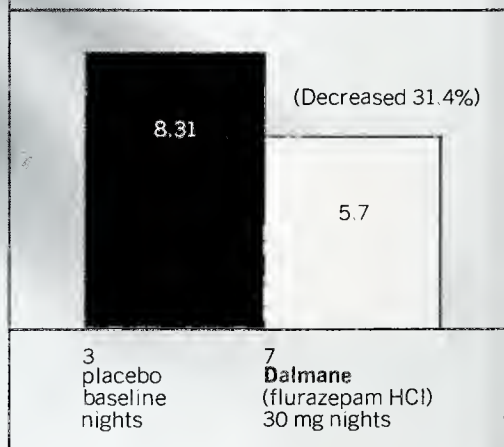


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Dalmane (flurazepam HCl) is relatively safe, seldom causes morning "hang-over"...

...and is well tolerated. The usual adult dosage is 30 mg *h.s.*, but with elderly and debilitated patients, limit the initial dose to 15 mg to preclude oversedation, dizziness or ataxia. Evaluation of possible risks is advised before prescribing.

REFERENCES:

Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971

Frost JD Jr: A system for automatically analyzing sleep. Scientific exhibit at the 44th annual Clinical Convention of the American Medical Association, Boston, Nov 29-Dec 2, 1970; and at the 42nd annual scientific meeting of the Aerospace Medical Association, Houston, Apr 26-29, 1971

Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
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Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly

or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

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Mr. R. L., 50, has only 10% of his sight. Mrs. J. D., 39, spends three days a week attached to an artificial kidney. Billy, 6, suffers from a serious blood deficiency.

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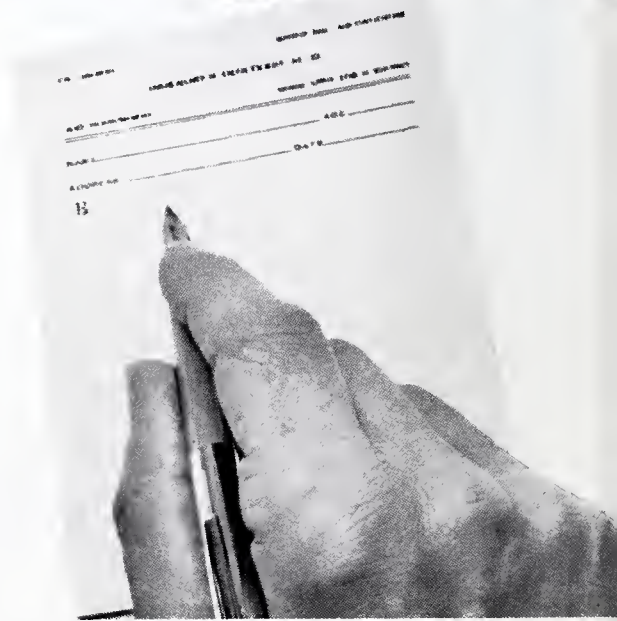
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Bioequivalence



the weight of scientific opinion:

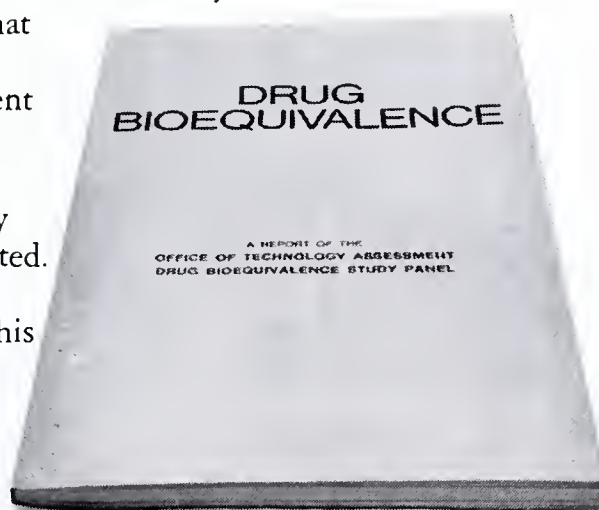
If the pharmacist substituted a chemically equivalent drug for the one you have specified for your patient—could you be certain of that product's safety and effectiveness simply because the chemical content was the same?

Definitely not, unless bioequivalence tests and other quality assurance checks had been conducted. The pharmaceutical industry and many scientists have maintained this position for years, but others have questioned it. Now the Office of Technology Assessment of the Congress of the United States has reported on the issue in its Drug Bioequivalence Study.*

Here are a few definitive statements in the O.T.A. report:

"...the problem of bioinequivalency in chemically equivalent products is a real one. Since the studies in which lack of bioequivalence was demonstrated involved marketed products that met current compendial standards, these documented instances constitute unequivocal evidence that neither the present standards for testing the finished product nor the specifications for materials, manufacturing process, and controls are adequate to ensure

that ostensibly equivalent drug products are, in fact, equivalent in bioavailability.



"While these therapeutic failures resulting from problems of bioavailability were recognized and well documented, it is entirely possible that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

The Pharmaceutical Manufacturers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical products, subject to new drug procedures, to document:

(a) chemical equivalence; and

(b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or
(c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual inspections and certification thereafter, and strict adherence to FDA regulations on good manufacturing practices.

The overall quality of the United States drug supply is excellent. But only a total quality assurance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription...



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

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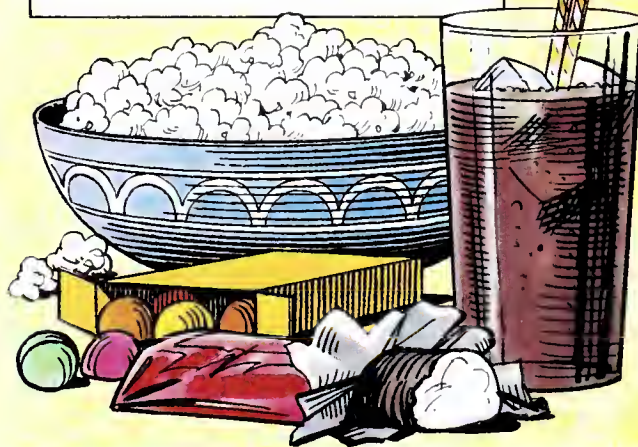


The Indian fruit-eating bat, almost all monkeys, man and the guinea pig are the only mammals whose bodies lack an enzyme needed to synthesize ascorbic acid from glucose! Hence they must obtain their vitamin C from exogenous sources.



De Joinville writing about a 13th century crusade reported that barber surgeons had to "cut away the dead flesh from the gums to enable people to masticate their food." The disease he described was probably scurvy.

A 1965 U.S.D.A. survey revealed that American diets were lower in vitamin C than they had been 10 years earlier!

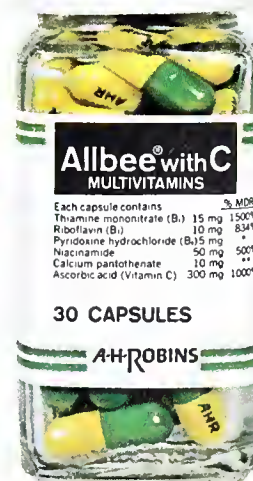


The outer leaves of cabbage and brussels sprouts contain more vitamin C than the heads. Yet, ironically, these are often trimmed away by the grocer to improve appearance and enhance sales appeal! Many housewives trim them even more before cooking!

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Brief summary. Adverse Reactions: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Contraindications: Glaucoma; renal or hepatic disease; obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); or hypersensitivity to any of the ingredients.

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are prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

WARNING

This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy tailored to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated conditions in each patient warrant.

Indications: This combination drug finds its usefulness primarily in the treatment of edema. Any usefulness of triamterene when used with a thiazide in hypertension will derive from its potassium-sparing effect. Either its main diuretic effect or potassium-sparing effect when used with a thiazide drug should be determined by individual titration. (See box warning.)

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly reduced. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If furosemide is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' carefully for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and nitrogen determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-thoractomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria, diabetic insulin requirements may be altered, digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with hypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with crescent measurement of quinidine.

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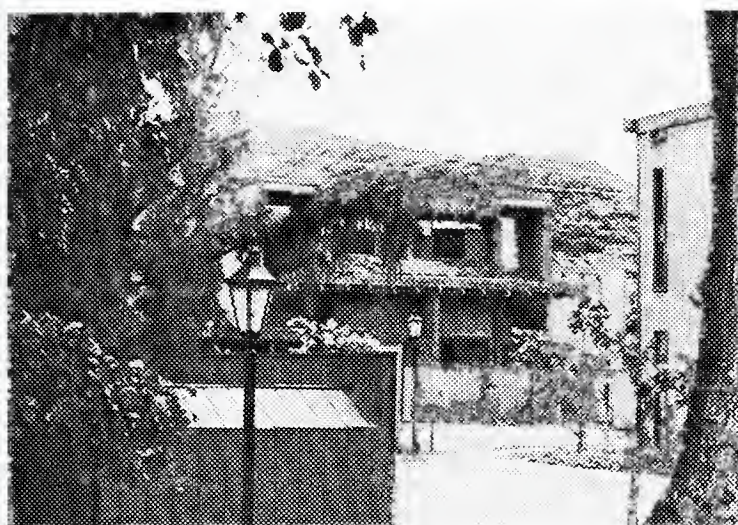
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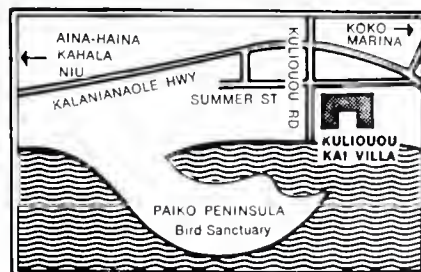
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If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.

Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens

should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.

Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:

nausea, vomiting, anorexia
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breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)

breast tenderness and enlargement

reactivation of endometriosis

possible diminution of lactation when given immediately postpartum

loss of libido and gynecomastia in males

edema

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If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

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Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

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Football Injuries of the Cervical Spine and Cord

M.M. OKIHIRO, M.D.; R. TANIGUCHI, M.D.; and
H.W. GOEBERT, M.D., *Honolulu*

Football is probably THE national sport in our country, and certainly in Hawaii it has gained acclaim as the number one sporting event in high schools and at the University of Hawaii.

Unfortunately, football is at times a dangerous game. Although most of the injuries are of a minor nature, an occasional serious and disastrous injury is seen. Probably the most serious of these are injuries to the central nervous system, that is, the head and neck. With the improvements in the make-up of the helmet, serious head injuries appear to be less common, but serious injuries to the cervical spine and spinal cord seem to be on the increase.

The following case reports are examples of some injuries seen during the 1973 and 1974 football seasons in Hawaii. They are presented to call attention to some of the dangers which are inherent in the sport as it is now being played.

Case Report 1

This 15-year-old youngster was a tackle on a high school junior varsity (JV) team. During a practice session he hit one of his teammates solidly with his left shoulder and head. He developed immediate neck pain and numbness of his left arm. Thereafter each time he hit someone he noted a painful tingling in his left arm. When seen by a neurosurgeon a few days later he had limitation of neck motion with marked weakness of the left deltoid and moderate weakness of the left biceps muscles. His left biceps reflex was absent, but the sensory examination was unremarkable.

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Cervical spine films, with flexion and extension views, revealed excessive movement between C4 and C5. A myelogram was performed and was normal. He was treated conservatively with a soft cervical collar. After a month the deltoid and biceps weakness had disappeared and the biceps reflex returned.

Comment: This youngster had a "nerve pinch" injury with radicular involvement of the 5th cervical root. The excessive movement noted between the vertebrae on the x-ray studies make it apparent that he had suffered a subluxation and had an unstable joint between C4 and C5.

Case Report 2

This 16-year-old was on the kick-off and punt squad of a high school varsity football team. His coach had been "down" on him, calling him "pokey" because he was slow and seemingly was not giving his "all" to the game. The patient said that he was determined to get into a tackle and show his coach that he could do the job.

On the next kick-off he raced headlong towards the runner. He does not know what he hit, but apparently he slid off another player and then does not know exactly what happened. He noted severe pain in his neck and left shoulder, with numbness and paralysis of his left upper extremity as well as some weakness in his left lower extremity. He was taken to the hospital by ambulance.

In the emergency room he was noted to be alert with some neck pain, which gradually subsided over the next hour. However, he was left with a complete motor paralysis and sensory loss of his left upper extremity, which began to improve over the next three hours. Reflexes were absent in the left upper extremity but present in

the lower extremities. Plantar reflexes were flexor. X-rays of the cervical spine were normal. Over the next five days he had gradual improvement and was discharged from the hospital.

Comment: The exact diagnosis and mechanism of injury in this case was undetermined. There was some question as to whether the primary problem was a cervical cord concussion or a brachial plexus stretch palsy. The former would seem more likely in view of the initial weakness in his left lower extremity.

Case Report 3

This 14-year-old youngster was a safety on a JV football team. He came up to tackle the opposing team's fullback, who had run through the line and secondary. The patient said that at the moment of impact he put his head down in a flexed position and was struck by the ball carrier's knee squarely on the top of his helmet. He noted immediate neck pain and a transient sensation of numbness around his neck. When examined by a neurosurgeon, except for the neck pain and slight limitation of motion, the neurological examination was negative. However, x-rays of the cervical spine showed a shattered fracture of the atlas, the so-called Jefferson fracture.

Comment: This boy suffered a serious fracture of the atlas but fortunately did not suffer any neurological deficits. Fortunately, the line of force was such that neither flexion nor extension of the spine occurred.

Case Report 4

This man, who just turned 18, was a freshman left guard on the offensive squad of a college football team. He said that on this particular play he pulled out from his position on the line to run interference for the running back and his job was to block the defensive left end. He had always been trained to hit the opponent as low as possible with his head down and to come up at the moment of impact, but he said that on this particular play the defensive end was also crouched very low. His head was flexed and apparently met the opponent's head which then slid over his. He fell in a flexed position, and noted immediate pain and paresthesias in the back of his head and neck. He could not move his extremities, but retained consciousness throughout the incident. He was taken to a local hospital by ambulance, and when seen by a neurosurgeon he was quadriplegic. X-rays of his cervical spine showed a fracture-dislocation of the C4-5 interspace. A posterior laminectomy and fusion was performed.

At the present time he remains completely paralyzed in his lower extremities. In his upper extremities he has fair deltoid and biceps activity but his triceps, forearm and hand muscles

are markedly weak. He notes numbness in the last two fingers of both upper extremities and in the lower extremities.

Comment: This young man suffered a fracture-dislocation of the cervical spine. His injury occurred in a position of forced cervical flexion, a position in which one is less able to withstand a blow as compared to a slight degree of extension.

Case Report 5

This 15-year-old sophomore had just been brought up to play for his high school varsity team. He was a defensive player on the kick-off team, and on this particular kick-off, ran full force toward the ball carrier. A review of the televised tapes taken at the game shows the victim with his head down, about to meet the ball carrier. At this point, the latter's knee or thigh catches the victim's faceguard or helmet, hyperextends his head and neck, and flips him backward. From the moment of impact, the youngster was rendered quadriplegic.

X-rays of his cervical spine showed a fracture-dislocation between C4-C5. A cervical fusion was done to stabilize his spine. He remains severely quadriplegic.

Comment: The mechanism of injury was a severe hyper-extension of the cervical spine. The force of the runner's knee and thigh was of such magnitude that it simply hyperextended and broke the victim's neck as the latter dove at the runner with his head down.

Discussion

In a survey of high schools in North Carolina from 1969 to 1972, approximately 48% of 8776 football players were injured.¹ A recent American Broadcasting Company (ABC) television documentary gave an estimated figure of 800,000 injuries per year. While these figures appear on the surface to be unduly large, and while some football coaches deny them as being outrageous², it is difficult to deny facts and figures.

The following data were recently obtained from Robert Kubo, Castle High School teacher and athletic trainer. Of 46 varsity players, 20 were injured to some degree and required medical attention. Ten of these youngsters were referred to and treated by a physician. Because of these injuries, 257 days of practice and 22 actual games were missed.

Peter Howard, the Punahou Academy trainer, is quoted as saying that 32 of 45 varsity players were injured in 1973, and 43 of 47 players required treatment in 1974.³ Thus, according to the data from these two schools, the figures from North Carolina and the ABC documentary may not be misleading at all.

In this paper, however, we are primarily concerned with the more serious of these football

injuries to the cervical spine and spinal cord. The examples given in the case reports reveal a variety of injuries and mechanisms producing these neck injuries.

What are some of the factors producing these neck injuries and what can be done about them?

Equipment The modern day helmet consists of a very rigid plastic shell surrounding and suspended on an inner skirt or crown made of sponge rubber or some other resilient material. It apparently has done its primary job of protecting the head quite well, but because of its toughness, the helmet has also become a weapon to punish the opposition, and sometimes something to hide behind.

The face-guard also has contributed to the problem, for no one would risk leading with his head without a guard for fear that he would deliberately injure his face and teeth. Furthermore, the faceguard has undoubtedly added to the frequency of hyperextension or torsion injuries to the cervical spine. While tackling by the faceguard is illegal, it is easy for the tackler's fingers to grab and hold on to a protruding faceguard so that this invariably happens, often accidentally, in game after game.

"Fritz" Crisler, who was once the chairman of the Rules Committee of the National Collegiate Athletic Association, estimated that there was a four to five-fold increase in neck injuries following the inception of the use of the faceguard and helmet.⁴ This figure seems not unlikely.

"Spearing" This is the technique in which a tackler forcefully drives his head as a battering ram into an opponent. The helmet and faceguard are used as weapons for the initial contact. While it may be effective in stopping an opponent, it is also the way to suffer a serious injury to the cervical spine. Despite many pleas to the contrary,⁶⁻¹⁰ it is said that the majority of coaches in Hawaii do teach blocking and tackling by the head.¹¹ One coach is quoted as saying that he'll continue to use head blocking and tackling unless it is made illegal.

The fact is that "spearing" is an illegal maneuver subject to penalty, but it has not been called by officials very often in the past. Yet, on the other hand, "butt-blocking", a technique in which the top of the head is the principal point of contact for blockers, is not prohibited. The difference between "spearing" and "butt-blocking" is a matter of semantics; the dangers are the same.

Tackling and blocking should always be taught with the face up. Warning the player is not enough. Time should be set aside to illustrate what spearing is, how it can hyperflex or hyperextend the neck and cause severe injury to the player who risks it, as well as to the opponent.¹²

Physique and Physical Conditioning "The youngster with the long thin neck who is tall and gangly without adequate musculature is a poor candidate for the rigors of football."⁵ The importance of building up the neck musculature by constant conditioning exercises in football players to withstand severe blows was recognized by "Red" Blaik years ago.¹⁴

An athlete with a long thin neck is more prone to neck injuries. A remedial program should include:

1. Strengthening program for the neck, shoulders and upper back.⁷
2. Shoulder pads properly fitted to prevent the head from excessive flexion to the side.
3. Providing neck collars to help prevent further excessive lateral neck flexion.
4. Evaluating the players blocking and tackling techniques.

"But even the best conditioning program cannot enable the immature spine and musculature of a 15 or 16-year-old to withstand the head-on force of a head butt" ("spearing").⁶

Matching Proper matching is important in any sport, and when athletes of similar physical characteristics and maturity compete, the game is fairer for all concerned. Although physiological age does not always correlate with chronological age, it is natural that in a violent contact sport such as football, the younger and less mature boy will be injured more often and more seriously.

Unfortunately, there is no way to match high school football players except by age. Although there are junior varsity and varsity teams, it is possible for a particularly talented, swift or big 13- or 14-year-old freshman to be playing against an 18-year-old senior. Since there is always a team for the good player, the varsity should probably be restricted to high school juniors and seniors. The less mature freshman and sophomore should stay with the junior varsity team, no matter how talented he is. The upper age limit should likewise be lowered to 18 years. It is not appropriate to reward the older individual by letting him shine against the younger.

The "Suicide Squad" The "suicide squad" is an appropriate nickname given to the special kick-off and punt return team. A large number of serious injuries occur on the kick-off and punt return, because opposing players are racing at each other and often collide head-on or head-to-knee.

Too often the "suicide squad" is made up of the less talented and less experienced players. Because they are eager to "show their stuff", and since they can only get into the game these few times, they charge into battle with abandon.

To justify football or any other sport, we should be able to prove that benefits and positive

values are to be gained from participation in the game. There is no question that football can present a meaningful challenge to the individual and provide him an opportunity for a physical and emotional experience not to be found elsewhere. Sometimes, however, the values are artificial ones created by overzealous coaches, alumni and rabid sport fans.

Football is a game of calculated risks,¹³ and the question is, as the game is offered today to our school children, is the risk too great? It would seem so when the game produces some of the serious injuries presented in this paper. The

presence of physicians and athletic trainers on the field to manage injuries is not enough. It is obvious that some changes will have to be made to prevent serious injuries and to make football a safer, healthier game.

Summary

Five case reports of teenagers with cervical spine and spinal cord football injuries during the past two seasons in Hawaii have been presented. Some of the factors contributing to these serious injuries have been delineated, and suggestions offered in an attempt to make football a safer game for our youth.

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The Impact of Diet Education on the Patient with Adult-Onset Diabetes

EARLS.C. YOUNG, B.S. and RAY T. HUFFMAN, M.D., *Honolulu*

An investigation of 23 patients with adult onset diabetes revealed that only 3 were following a diabetic diet. These figures approximate those of most other similar studies. It is felt that a diabetic diet represents a more drastic imposition than most people can tolerate and should be considered in the same category with the treatment of obesity and alcoholism. Customary methods of diet instruction are ineffective in diabetes unless the dynamics of life style are taken into consideration.

Every major textbook emphasizes the importance of educating the patient with adult-onset diabetes, particularly with regard to dietary therapy. "Education of the patient," according to Cecil-Loeb, "is of paramount importance."¹ Harrison's textbook states that "dietary therapy still constituted the basis for management" of diabetes mellitus.² Tice and Harvey similarly

views the patient as his own therapist with the physician acting as a consultant.³ With this in mind, a survey of patients was carried out to determine the extent to which principles are translated into practice.

Method

Twenty-three patients with mild adult-onset diabetes were selected from Hawaii's three major general hospitals during the month of July. An open-ended question format was employed to avoid rigid and superficial responses inherent in fixed-answer questionnaires. A rating scale of poor-fair-adequate was employed by the single interviewer who gathered data. "Adequate" knowledge was judged to be an answer which allowed the patient to respond correctly if confronted by an unfamiliar situation.

Questions asked during the interview included ones concerning duration, source, and thoroughness of knowledge of diabetes. Dietary knowledge as well as adherence to diet was ascertained. Finally, frequency of urine and serum glucose measurements was recorded.

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Results

The mean time from diagnosis in our patient population was 7-8 years, with three patients having their diagnoses within one year. Nine patients found out about their disease in their doctors' office whereas the rest learned during a previous hospitalization. Most patients had their urine checked regularly by their physician either every month or every three months. Blood glucose was checked twice a year on the average.

Eighteen patients (78%) claimed to have been given advice relating to their disease and diet instruction by their doctor or dietician. Five patients denied having been taught anything in this regard.

When asked, "what do you know about diabetes," gross inadequacies of knowledge were revealed. Almost all the patients described diabetes as an incurable disease which leads to blindness, amputation, or heart disease if not well controlled. Six patients knew nothing about the disease. Only one patient gave a reasonable description of "insulin deficiency leading to inability of the body to handle sugar."

Only three out of the total of twenty-three patients followed a diet. One was in a nursing home where his meals were planned for him. Another was suffering from cerebral vascular complications (strokes) and appeared motivated mainly through fear of having his condition worsen. The third patient was a karate instructor whose livelihood depended upon his top physical condition. All nineteen patients who were not on a diet knew what they were supposed to eat in spite of their failure to do so. These results suggest that a diet is effective only if the lifestyle of the patient can incorporate it.

Discussion

The importance of dietary control of diabetes has been empirically evident for centuries. In 1958, Daughaday, writing for the AMA's nutrition council, stressed the importance of the diabetic diet both as an educational tool and as a means of integrating or eliminating the role of drug therapy.⁴ This weighty publication should have served as the impetus to full utilization of dietary therapy. It, along with a mul-

titude of similar publications, has failed to have significant impact on the control of diabetes.⁵⁻¹⁰

In 1961, Stone conducted a survey of the causes of poor control in patients with diabetes mellitus.¹¹ The diabetes portion of the 1968 National Health Survey reported that 47% of all diabetics do not follow a prescribed diet. Of these, 50% claim that they have never been given a diet while the other half did not follow the one given to them.

Our data suggests that although currently more patients are receiving diet instructions, fewer are following them. This is due to the fact that the literature abounds with publications regarding principles of therapeutic dietary regimens.

In 1966, Etzwiler conducted a study on the knowledge of educators of patients with diabetes.¹³ He found "an appalling lack of information concerning basic concepts" of diabetes. The current deluge of drug company literature has made it virtually impossible for any patient to avoid receiving some form of educational material about diabetes.

Why, then, is there patient-failure to implement a diet? The obvious answer is that mild diabetes is not serious enough a condition to warrant such a drastic change in style of living (diet) which is required for its control. Unless the diet becomes part of the patients' *raison d'être*, the therapy is doomed to fail. Groups such as Synanon, Alcoholics Anonymous, and Weight Watchers are successful because they realize this fact.

Since diabetic patients who are free of serious complications are unwilling to admit their condition, the role of the physician would appear to be not that of a passive advisor but that of an active counselor to achieve a change in lifestyle. Continuous follow-up and reinforcement are the fundamentals which will sufficiently impress the importance of dietary control.

Dietary therapy as it exists today is neither educational nor effective. It fails miserably as the principal mode of therapy. Rewriting the textbooks to fit the current situation would be far easier than achieving good control through close, intensive patient follow-up. However, the only choice which is meaningful for the doctor and beneficial to the patient is the latter.

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12. Holland WM: The Diabetes Supplement of the National Health Survey, *J Am Diet Assoc* 52:387-390, 1968.
13. Etzwiler DD: Who's Teaching the Diabetic? *Diabetes* 16:111-117, 1967.



H. TOM THORSON

Dr. William Dang and Tom Thorson met with National Conference of State Legislatures in Washington D.C. relative to malpractice insurance problems. They were accompanied by legislators Dennis O'Connor, Anson Chong, Herbert Segawa, Lisa Naito, George Clark, Henry Peters, and possibly Clifford Miyoi from the Department of Insurance.

Dr. Alan Pavel attended meeting of orthopods in the same subject in Chicago. All of this is in the direction of making some decisions as to the way to go to resolve the problem. With physicians in San Francisco, Florida, New York, and other areas going on emergency care basis only something will have to give. Our situation in Hawaii is unchanged. Argonaut will still accept new applications and in spite of rumors to the contrary there has been no firm decision to terminate on any specific date. This decision will not be made until other problems on the mainland are resolved.

We may have a special bulletin if something breaks for us.

AMA and NATIONAL NEWS—

Colorado court enjoins optometrists from detecting and diagnosing glaucoma and prescribing soft contact lenses for therapeutic measures. UR regulations delayed until July 1, pending outcome of AMA suit against HEW contending the regulations interfere with the practice of medicine. AMA also planning suit if MAC (maximum allowable cost) regulations are implemented. The regulations would establish a maximum allowable cost reimbursement for drugs on the assumption of chemical equivalency.

AMA guidelines for National Health Insurance seek to establish:

1. Minimum federal involvement
2. State jurisdiction
3. No added Social Security tax

4. No administration by Social Security
5. Use of private insurance industry on risk basis
6. Pluralism in methods of delivery
7. Tax credits for full health care protection

Not everybody is agreed the AMA should endorse compulsory participation.

LEGISLATION CONSIDERED—

S. 215—National medical injury compensation act—opposed

S. 484—National Medical malpractice insurance and arbitration act—opposed

S. 188—Federal malpractice insurance act—opposed

S. 522 and HR 2525—Indian health care improvement act—support

H.R. 1—National Health care service reorganization act—opposed

S. 3—Health Security Act—opposed

H.R. 5000—Emergency health insurance extension act (to meet needs of the unemployed for insurance during unemployment period)—support

AMA disapproved request for funds to finance the formation of a national association of PSROs. The PSRO program seems to be in some trouble financially with funds available only for 14 existing PSROs. Priorities are being reevaluated.

NEW REGULATIONS tying physicians fees under medicare to economic indices so that medicare costs will follow rather than coincide with inflationary trends have been proposed. Regs would provide for reimbursement on 75th percentile based on 1973 prevailing charges corrected to reflect changes in fiscal 1971. Increase would be limited to amount suggested by index. SSA expects to save \$30 million during first fiscal year. The amount saved would come from the physicians reimbursement. Then they ask for increased acceptance of assignments!

MEETINGS—(Not included in CME for Category I) American Society of Law and Medicine—Statler Hilton Hotel, Wash. DC, June 8-10, 1975 —Contact American Society of Law and Medicine, 454 Brookline Ave., Boston, Mass. 02215. Approved for Category II.

Psychosomatic Medicine—Rome and Sicily—September 13-29, 1975. Contact Institute for Continuing Education, P.O. Box 11083, Richmond, Va 23230. Congress of Radiology-Singapore, Bangkok, and Hong Kong. November 10-23, 1975. Contact—Institute of Continuing Education—(same as above).

Clinical Immunology and Allergy—Riviera Hotel, Palm Springs, Calif., October 15-19, 1975. Contact Howard Silber, AACIA, P.O. Box 912. DTS. Omaha, Nebraska 68101. LOCALS—Professional Liability Committee con-

sidering preliminary plans for possible emergency program if insurance programs come apart.

HEALTH PLANNING state agency for single area announced by Governor Ariyoshi. This is in accordance with PL 93-641. There will be more on this at a later date.

JCAH not scheduled to survey hospitals in Hawaii during second quarter of 1975.

JCAH approved long term care facilities—
Hale Nani Hospital
Maluhia Hospital
Maunalani Hospital
Convalescent Center of Honolulu
Island Nursing Home

GOVERNOR ARIYOSHI requests nominees for Board of Medical Examiners from HMA.

MEMBERSHIP AWARD presented to HMA for 1974 membership growth—came from AMA.

Dick Omura resigned from Community Health Planning Committee because of other pressures—George Mills has been appointed as replacement.

Ann Catts and Fred Gilbert appointed to Laboratory Advisory Committee of DOH.

Dr. Bill Dang and Tom Thorson will meet with Senator Inouye on May 8, in Washington, D.C.

HMA has signed contract for Tumor Registry with Cancer Center.

Pharmacy Committee and Postgraduate Education Committee planning for symposium—possibly in August in cooperation with Lederle.

Patient education program proposed by DOH—Fred Reppun will represent HMA.

EMS program moving in direction of transferring equipment to operating agencies.

HMA implementation will be finished June 30, but HMA probably will continue as training agency for personnel.

OPPORTUNITIES for Internists at UH School of Medicine, contact Dr. C.L. Gulbrandson, 1301 Punchbowl Street, Honolulu 96813.

Wanted is a physician for University Health Service—special interest in working with young adults—contact Dr. Donald Char, Student Health Service U of H, 1710 East West Road, Honolulu 96822.

JOB WANTED by experienced Medical Secretary—call HMA office for name of mainland applicant.

AVAILABLE PHYSICIANS—We have entirely too many applications from physicians on the mainland wanting to come to Hawaii. It is impossible to list them. Anyone interested please come to the office to review the file to see if an applicant may suit your needs—practically all specialties are represented.

DUES ARE DELINQUENT and those not making arrangements or payment prior to May 5 are dropped from membership. Reinstatement can be accomplished only by making full payment, but in the meantime journals are cancelled, insurance can be jeopardized, so we hope that those few did get all straightened out.

SIDELIGHT—One member cancelled because of AMA stand on New York House Staff dispute. Another rejoined because of the same thing—no way to satisfy everybody.

AMA Annual Meeting—Atlantic City, June 14-18. Attend and express yourself at the reference committee meetings.

AMA made major staff reduction on May 1. Advice received by wire announced reduction of 77 staff members on May 1. Staff has been reduced from 932 one year ago to 824. The details are not known at this time but it appears that one section to be abolished was the Division of Investigation. Nineteen of the 77 were scheduled for early retirement.

A CHECK for \$4,259.75 was presented to the University of Hawaii School of Medicine by Mrs. Donald Jones, president of the Auxiliary to the Hawaii Medical Association, on behalf of AMA-ERF.



Quality of Health Care

Trust

Quality of health care is measured primarily in terms of rapport between the giver and the taker. This means that the patient must have a good feeling, of confidence, of liking, of respecting, and of satisfaction; that the practitioner of the healing arts feels good likewise in dealing with his patient, whom he can trust as understanding and cooperating. There simply HAS to be mutual confidence. It can be strained and tested at times, but like the apron

strings that tie mother to child, it must remain unbroken; on the other hand, this confidence must not be mandated by law, by regulation, or by pocketbook—if the rapport is broken, then let the contract be dissolved as easily as possible.

Competence

Quality care involves scientific and technical competence on the part of the practitioner. This is presumed when s/he is licensed to practice the particular profession. Unfortunately, boards of licensure are made up of human beings who have their failings, as we all do. The system is not perfect, and we as a society should strive continually to make it more nearly perfect and to change with the times. The system should recognize human frailties also, and therefore not be so restrictive or punitive so as to stifle development of effort and service.

Up-dating

Emphasis needs to be placed on the realization that every practitioner **LEARNS** from every case and patient he treats. It is not particularly true that "education" stops at "graduation" and that its half-life is short. Most practitioners educate themselves continuously: by studying, by reading, by discussing cases with colleagues; they can hardly escape the flood of literature, much of it extremely attractive, thrown at them; they are attracted to listen to the leaders in their field at attractive meetings; they are pushed continually by their patients, who have become remarkably aware of things medical. Certification of attendance and of continuing education is not a proven assurance of quality care update, although it helps to establish some measure of proof. This is not to deny that there are practitioners who stop learning, who repeat the same old mistakes, and who give the profession a black eye. However, there is a self-limitation to these: They begin to lose their reputations and their practice; they become involved in malpractice suits. (Unfortunately, the best practitioners also suffer such suits, and it costs a lot of money to win them!) Just because there are a few bad eggs among us—which we strive mightily to weed out (often the lawyers prevent us from doing this!)—is no reason to castigate all practitioners, and to place unreasonable restrictions upon them.

The Art

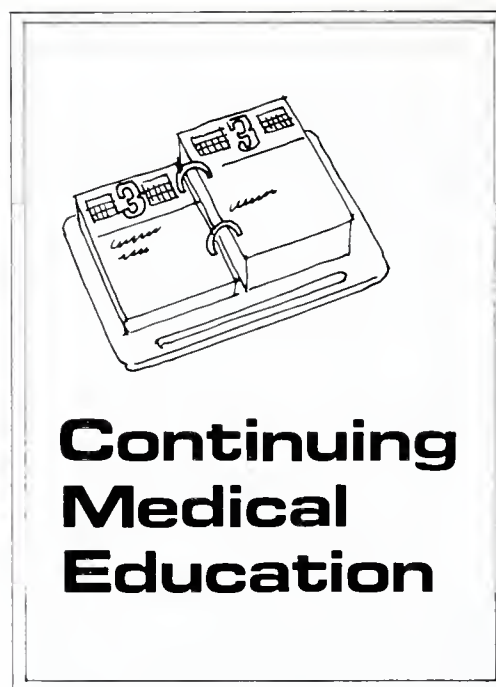
Was it Barnum who said there was a sucker born every minute? Healing is defined most commonly as an art, and not a science: "The Healing Arts." Quacks flourish as well as university medical school professors. One cannot legislate "suckers" out of existence. Neither is it possible to eliminate "quackery"—as long as suckers exist. These are facts of life that need to be accepted. True, attempts should be made to educate the public against them both. The problem is much smaller than played up to be.

We must grant, however, the possibility that where science can fail, the art can succeed. Certification or relicensure, and its concomitant continuing-medical-education concept, will not and cannot measure the "art" of healing. Many practitioners whose scientific knowledge may not be quite up to the times, continue to practice successfully—in terms of "healing" by means of their art. Let us not shut them out forever.

Costs

Quality of health care also includes a focus on the part of both practitioner and patient on the costs of same. Either or both parties can and do contribute to abuses. This is all the more a fact of modern life with the advent of third party insurers, and this includes the biggest insurer of all: the government. If the practitioner is restricted by the budget, his freedom to provide top quality is curbed. If the patient is restricted by his own pocketbook, he is likely to hold back from requesting and receiving top quality care. We need to focus on reasonable compromises. We need to avoid harmful restrictions on either side. Third parties tend to be more money-conscious than quality-conscious.

JIFR



Continuing Medical Education

ELIZABETH K. ANDERSON, M.D.

NEWS IN CME:

Kuakini Hospital's Program of CME was surveyed in April by an HMA team consisting of Drs. Edgar Ho (Chairman), Richard Tesoro and Leonard Jacobs and was granted two-year provisional accreditation by the Medical Education Committee. Its accredited programs are listed below.

Wilcox and Kaiser Hospital Programs will be surveyed next.

HAVE YOU OBTAINED THE PHYSICIAN'S RECOGNITION AWARD? IS IT CURRENT?

A brief review of requirements and various categories of CME as described in the AMA booklet may be in order. 150 hours of overall CME credit over 3 years is required, the breakdown as follows:

Category 1: CME programs with *accredited* sponsorship—60 hours required, no limit. "Accredited sponsorship" means the program is given by an institution whose CME structure is approved by the AMA Council on Medical Education of which the HMA is an approved accrediting arm. Category 1 involves programs of CME which are **planned, coordinated, administered, and evaluated** in terms of specific educational objectives for a defined group of physicians or for an individual physician. It can also include grand rounds, scientific meetings of medical and medical specialty societies, visiting lecturer programs and some teaching in accredited institutions.

Category 2: CME activities with nonaccredited sponsorship (limit 45 hr. credit)

Category 3: Medical teaching (limit 45 hr. credit). In accredited institutions, some of this can be Category 1.

Category 4: Papers, publications, books written (limit 40 hr. credit)

Category 5: Non-supervised individual CME (reading, self-instruction, consultation, patient care review (routine), self-assessment, specialty board preparation (limit 45 hr. credit)

Category 6: Other meritorious learning experiences; i.e. CME not falling in Categories 1-5 (limit 45 hr. credit)

Details of each category are described in the AMA booklet on the PRA. Note: Applications for the 1974 Award cannot be accepted after June 30, 1975.

CALENDAR OF ACCREDITED EVENTS—CATEGORY I

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS:

Kauaikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital

1. Tuesdays—CME Program, 1:00-2:00 p.m.
2. Grand Rounds, 2nd and 4th Mondays—5:00-6:00 p.m.
3. Visiting Professor Programs (see Special Events)

Kuakini Hospital

Ongoing

1. Hematology Conference, Monday, 8:30-9:30 a.m.
2. Gastroenterology, Tuesday, 8:30-9:30 a.m.
3. Oncology, Thursday, 8:00-9:00 a.m.
4. Endocrine, 2nd Tuesday each month, 1:00-2:00 p.m.
5. Medical Statistics, 3rd Tuesday each month, 1:00-2:00 p.m.

Special

May 21—Arthritis Grand Rounds sponsored by Arthritis Center, 7:30 a.m.

SPECIAL EVENTS:

May 19-22 *Obstetrics/Endocrinology and Infertility—*
USC at Mauna Kea Beach Hotel,
Kamuela

Contact: Phil Manning, M.D., Assoc. Dean
Postgraduate Division
University of Southern California
School of Medicine
2025 Zonal Avenue
Los Angeles, California 90033

June 1-4 *Fifth Hawaii Emergency Services Physi-
cian's Seminar* sponsored by HMA EMS
Program and Hawaii Chapter of ACEP at
Kaiser Hospital, Pacific Building Audi-
torium. For further information and pre-
registration, call EMS Program at
538-9011, ext. 471.

June 8-13 Pacific Association of Pediatric Surgeons
Royal Hawaiian Hotel, Honolulu
Contact: Walton K. Shim, M.D.
1481 S. King Street
Honolulu, Hawaii 96814

June 12-17 Pacific Dermatologic Association
Hilton Hawaiian Village, Honolulu
Contact: Robert J. McNamara, M.D.
2828 Telegraph Avenue
Berkeley, California 94705

June 16-18 *HMA Cancer Seminar*
Further details will follow. Watch this
space for announcements.

June 11-24 Kapiolani Hospital Visiting Professor
Programs, C.D. Christian, M.D.

August Conference on Alcoholism sponsored by
Hawaii Psychiatric Society, APA, HMA,
and University of Hawaii—Dates and
details to follow. Contact: Dr. Schnack

August Kapiolani Hospital Visiting Professor
Programs, M. Stenchever, M.D.

September 21 *"Hypertension"* sponsored by Hawaii
Heart Association and Hawaii Medical
Association, Princess Kaiulani Hotel.
For further information call Mrs. Austin,
Hawaii Heart Association, phone 538-7021

OUT OF STATE:

AMA Regional CME Programs--

8 Courses offering Category I credit

- 1) Dermatology for non-Dermatologists
- 2) Infectious Diseases and Antibiotics
- 3) Fluid and Electrolyte Balance
- 4) Venereal Disease
- 5) Pulmonary Function and Blood Gases
- 6) Basic and Advanced Support CPR
- 7) Basic ECG
- 8) Human Sexuality
 - a) Minneapolis, Minnesota (July 26-27)
 - b) Williamsburg, Virginia (September 27-28)

For further information, write:

Department of Scientific Assembly

American Medical Association

535 North Dearborn Street

Chicago, Illinois 60610

American College of Physicians Courses:

June

2-6

Hematology and Oncology

University of Chicago Cancer Research
Center, Chicago, Illinois

June

23-27

*Advances in Internal Medicine: Horizons
and Perspectives*

University of Alberta, Banff, Canada

For further information, contact:

Registrar of Postgraduate Courses

American College of Physicians

4200 Pine Street

Philadelphia, PA 19104

Further listings: For further detailed listings of numerous
Category I accredited CME courses taking place in Cali-
fornia and in other states, see the CME Bulletin Board
at the HMA Office or refer to the JAMA special issue on
continuing medical education. Listings of weekly lectures
and rounds of *not yet accredited local institutions* (Category
2 credits) will also be posted as they are received.



Hawaii Academy of Family Physicians' Newsletter

J. I. FREDERICK REPPUN, M.D.

1977

We wish to call your attention to the fact that 1977 is
the last year that Family Physicians will qualify to
take their "Board". After that they must have resi-
dency training to be eligible.

Congratulations—The following members elected to move back into the ranks of the "young": **Verne Adams, Jim Fleming, Homer Izumi, Herman Kramer, H. B. Luke** and **George Tyau** requested that their status be changed from "Active Exempt" to "Active"!

Tom Cahill, who has taken over the **Fred Dodge** practice, has become Active from Associate.

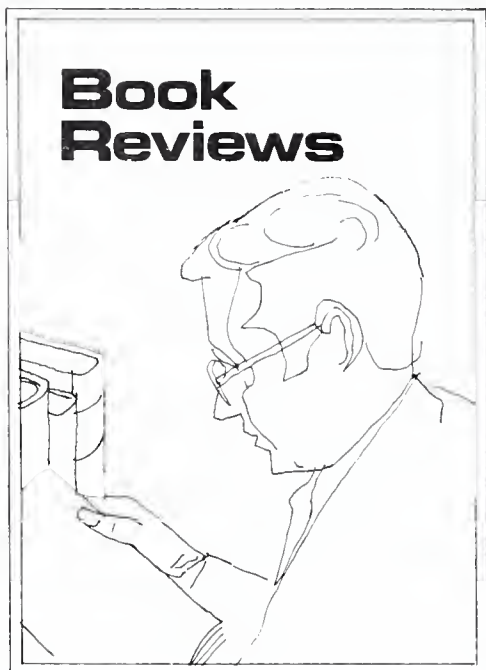
Dale Wicklund, UHSM IV, made the newspapers by being one of 48 winners in the U.S.A. and Canada of a fellowship of 3 months and will be assigned to: "A rural mission hospital in remote part of the Third World".

Necrology—We were very sorry to learn that former and long-time member **Hoichiro Uchiyama** died 9 April 1975. Dr. Uchiyama was graduated from Jefferson Medical College of Philadelphia in 1929 and began practice in Honolulu in 1931. He joined the Academy in October 1959 and resigned in September 1974, having been Inactive since 1971.

NEWS of Members—Col. **Bill Brownlee**, head of the Family Practice Section at Schofield Barracks and Tripler, will be retiring in September this year and plans to take up civilian family practice in Colorado Springs at the Fort Carson Army Hospital. Bill, we'd rather you retired to Hawaii! **James Langworthy** on Lanai has changed his membership category from Associate to Active; **Buz Willett's** new address is **Not** in California but c/o Gen'l Deliv. Kamuela 96743. **Gerald Yorioka** sent one of his neat-language gems in to the editor, *Star-Bulletin* (4/8/75) concerning mal-practice insurance and castigating the legal profession. On the same subject, **Doris Jasinski** is in close contact with lawyer/legislator John S. Carroll.

HAFP Dinner Meetings—have really been fun and worthwhile—2 hrs P credit too! On 22 February it was held at Col. Brownlee's at Schofield Barracks with Mrs. Brownlee as our gracious hostess. The total attendance was 31 of which 15 were actual members. On 26 April the meeting was held at the home of **Pat and Carolyn Walsh** in Nuuanu with 38 present of whom 21 were members. Those of you who are staying away are missing conviviality and education! The next one will take place on 28 June, time and topic to be announced.

HISTORY continued—**Varian Sloan** says: "The late **John Felix** came to a meeting of the California Academy of General Practice at the Coronado Hotel in San Diego in 1950 to find out how to organize a chapter." From the large number of current members whose membership dates to 1951, it can be assumed that the Hawaii Chapter can celebrate its 25th anniversary this year. Varian says he came to Honolulu in 1953 and gave an address to the new Chapter; he had been on the Board of Directors, and was then a member of the AAGP Commission on Education. Varian moved to Hawaii in 1954 and transferred his membership then. Any additional information on Hawaii Chapter's origins would be welcome.



Hawaii Medical Library News

NEW COMPUTER SERVICES

Patrons familiar with the Library's reference services know about MEDLINE, a computerized bibliographic service that provides rapid access to medical periodical literature. A MEDLINE search provides a user with a one time bibliography designed to meet his specific topic of interest from the 2400 medical and 600 nursing and dental journals that comprise the computer data base for *Index Medicus*, *Nursing Literature Index*, and *Index to Dental Literature*.

The Library is now pleased to announce the availability of two new computer services: BACKFILE and CCALINE. BACKFILE permits computer searches for the period January 1969 through December 1972, thus doubling the amount of retrospective searching previously available through MEDLINE. CCALINE (for Cancerline) permits computer searching on the *Chemotherapy Abstracts* data base for the period 1968-1972. Eventually CCALINE will include *Chemical Abstract* numbers, *Smithsonian Science Information Exchange Notes*, *Carcinogen Abstracts*, and *Research in Progress* computer data bases, making CCALINE an authoritative source for computer searching of cancer literature.

REFERENCE SERVICE AVAILABLE

Do you have a bibliographic question you want answered? If so, please call the Library at 536-9302 and ask for the Reference Librarian **Miss Ann Koto**. Within the past two months she has provided bibliographic information to patrons on the following variety of topics:

- Diseases of the Pituitary Gland
- Guidelines for a Physician's Widow
- Suicide in Middle Age
- Hair as a Protection Against Burns
- Children with Short Stature
- History of Waimano Home
- Immunologic Aspects of Transplantation
- Hodgkin's Disease Classification and Staging
- Availability of Dental Education Resource Material

Miss Koto will be most happy to answer your bibliographic question.

New Book Acquisitions: A Selected List

CARDIOVASCULAR SYSTEM

Essentials of pediatric cardiology, by Dennis J. Vince. Philadelphia, Lippincott, 1974. WS 290 V767e 1974

Exercise testing and training in coronary heart disease, by Jean M.R. Detry. Baltimore, Williams and Wilkins, 1973. Oversize WG 141 D483e 1973

The heart, arteries, and veins, edited by J. Willis Hurst. 3d ed. New York, McGraw-Hill, 1974. WG 100 H96 1974

COMPUTERS

Hospital computer systems, edited by Morris F. Collen. New York, Wiley, 1974. WX 26.5 H828 1974

DIABETES MELLITUS

The diabetic foot, edited by Marvin E. Levin and Lawrence W. O'Neal. St. Louis, Mosby, 1973. WK 835 L665d 1973

DIAGNOSIS

Interpretation of diagnostic tests; a handbook synopsis of laboratory medicine, by Jacques B. Wallach. 2d ed. Boston, Little, Brown, 1974. QY 25 W195i 1974

EMERGENCY MEDICINE

Emergency medical guide, by John Henderson. 3d ed. New York, McGraw-Hill, 1973. WA 292 H496e 1973

ENVIRONMENT

Environmental pollution by pesticides, edited by Clive A. Edwards. London, Plenum Press, 1973. WA 240 E5995 1973

Noise and man, by William Burns. 2d ed. Philadelphia, Lippincott, 1973. WV 270 B967n 1973

GENETICS

Medical genetics, edited by Victor A. McKusick and Robert Clairborne. New York, 11P Pub. Co., 1973. Oversize QZ 50 M159m 1973

GERIATRICS

Medical care and rehabilitation of the aged and chronically ill, by Freddy Homburger and Charles D. Bonner. 3d ed. Boston, Little, Brown, 1974. WB 100 H176 1974

MUSCULOSKELETAL SYSTEM

Disorders of the knee, by Arthun J. Helfet. Philadelphia, Lippincott, 1974. WE 870 H474m 1974

Management of acute head injuries: a biological approach, by Paul M. Weeks and R. Christie Wray. St. Louis, Mosby, 1973. WE 830 W396m 1973

Muscles alive; their functions revealed by electromyography, by John V. Basmajian. 3d ed. Baltimore, Williams and Wilkins, 1974. WE 500 B315m 1974

NURSING

History and trends of professional nursing, by Gerald J. Griffin and Joanne K. Griffin. 7th ed. St. Louis, Mosby, 1973. WY 11 J54g 1973

NUTRITION

Modern nutrition in health and disease; dietotherapy, edited by Robert S. Goodhart and Maurice E. Shils. 5th ed. Philadelphia, Lea & Febiger, 1973. WB 400 W84 1973

OPHTHALMOLOGY

Ophthalmology; principles and concepts, by Frank W. Newell and J. Terry Ernest. 3d ed. St. Louis, Mosby, 1974. WW 100 N54 1974

PATHOLOGY

Pathologic basis of disease, by Stanley L.R. Robbins. Philadelphia, Saunders, 1974. QZ 4 R636p 1974

PHYSIOLOGY

Medical physiology, by Vernon B. Mountcastle. 13th ed. St. Louis, Mosby, 1974. QT 104 M92 1974

PSYCHIATRY

The death of psychiatry, by E. Fuller Torrey. Radnor, Pa., Chilton, 1974. WM 75 T694d 1974

Male and female homosexuality; a comprehensive investigation, by Marcel T. Saghir and Eli Robins. Baltimore, Williams and Wilkins, 1973. WM 615 S129m 1973

RESPIRATORY SYSTEM

The lung in health and disease, by Charles F. Geschickter. Philadelphia, Lippincott, 1973. WF 600 G389L 1973

SPORTS MEDICINE

Head and neck injuries in football; mechanisms, treatment and prevention, by Richard C. Schneider. Baltimore, Williams and Wilkins, 1973. WE 700 S359h 1973

SURGERY

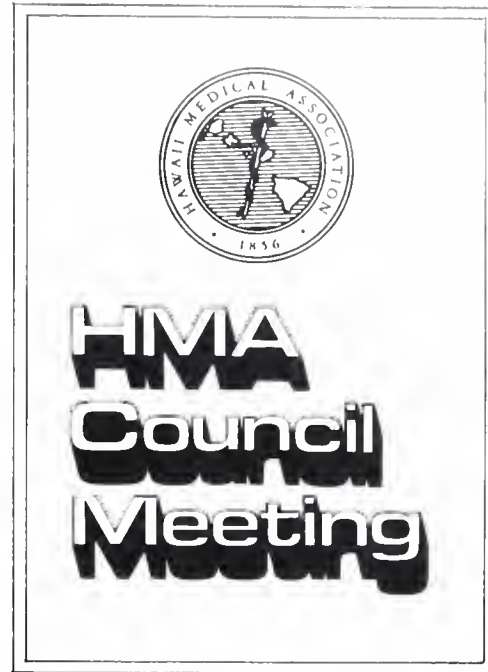
Demonstrations of physical signs in clinical surgery, by Hamilton Bailey. 15th ed. Baltimore, Williams and Wilkins, 1973. WO 141 B15 1973

DuVries' surgery of the foot, by Verne T. Inman. St. Louis, Mosby, 1973. WE 880 D987s 1973

Outpatient surgery, by George J. Hill. Philadelphia, Saunders, 1973. WO 100 H646o 1973

Fluid, electrolyte, and nutrient therapy in surgery, by Edward E. Mason. Philadelphia, Lea & Febiger, 1974. WO 178 M398f 1974

WALTER W. WALKER
Librarian



Friday, August 2, 1974, 5:30 P.M.
Mable Smyth Lanai

CALL TO ORDER

The meeting was called to order by President Thomas P. Frissell. Present were Drs. Winfred Y. Lee, William E. Iaconetti, R. Varian Sloan, Grover H. Batten, Herbert Y.H. Chinn, George Goto, J.I.F. Reppun, William W.L. Dang, Patrick J. Walsh, Douglas Bell, II, Sakae Uehara, Verne Adams, Peter M. Kim, William F. Moore, J. Mark Sowers, Calvin C. J. Sia, Rowlin Lichter, and E.K. Anderson; plus Messrs. V. Thomas Rice, H. Tom Thorson, Jon Won, Tom Leineweber, and Paul Steward.

MINUTES

The minutes of the June 7, 1974 meeting were reviewed. The first sentence of paragraph A under Medical Education and Peer Review, Report of the Committees and Commissions, was deleted.

ACTION:

It was voted to accept the minutes as amended.

Minutes of the special Council meeting on July 16, 1974 were reviewed. The last sentence of the minutes was reworded to read as follows: "The Board of Governors further voted that the Medical Plaza, Inc., be the vehicle to investigate further the development at this time of this project for both HMA and HCMS".

ACTION:

It was voted to accept the minutes as amended.

SECRETARY

The report of the Secretary was corrected as follows: Under the totals column for April 30, 1974, 749 should be 772, 72 should be 76, for a total of 946. Under May 30, 1974 the total amount should be changed from 901 to 929.

ACTION:

It was voted to accept the Secretary's report as corrected.

TREASURER

The June Financial Report was accepted subject to audit. Finance Committee Report: Experiencing a financial loss of \$26,804.23 over a 3½ year period the HAWAII MEDICAL JOURNAL is now showing a significant deficit for 1974. Faced with the prospect of incurring even greater losses on the JOURNAL, a joint meeting of the Finance Committee and the Publications Committee was held to determine what

course of action the HMA should take immediately and through the balance of the year. Several proposals were received. The Finance Committee and Publications Committee jointly recommend the prospect of a quarterly publication as soon as feasible and that the whole problem be brought before the House of Delegates in the Fall. Dr. Harry Arnold and Frank McDowell submitted a proposal to print the August and September issues in black and white; skip October and November issues; print a larger December issue in black and white; and publish quarterly in 1975. Paul Steward, Associate Editor of the JOURNAL, conducted a detailed study on the overall problem. Another alternative would be to dissolve the HMJ and become part of the WESTERN JOURNAL OF MEDICINE. There are many unanswerable questions such as whether or not the members of the Medical Association wish to continue the JOURNAL.

ACTION:

It was voted to allow the HMA officers to make decisions on the remaining issues of the HAWAII MEDICAL JOURNAL for 1974, and to present the problem before the House of Delegates.

REPORT OF THE COMMITTEES AND COMMISSIONS

A. Nominating Committee: The Committee elected Dr. Albert Chun-Hoon chairman, met and submitted the following nominations: President-elect, William W.L. Dang; Secretary, R. Varian Sloan; Councillor from Kauai, Peter M. Kim. The four nominations for Councillors from Oahu will be submitted at a later date.

B. Medical Education: The AMA Council on Medical Education has approved the Hawaii Medical Association as the accrediting body locally for continuing medical education programs for a one-year period. The Committee voted to charge a standard fee of \$200 to cover expenses incurred in carrying out surveys. Invitations have been mailed to hospitals and health agencies to apply for accreditation and favorable responses have been received. The HMA 118th annual scientific sessions will be surveyed by an AMA survey team in October, and surveys for the specialty societies will be conducted at that time.

C. Public Health:

(1) The Crippled Children's Committee wishes to refer the matter of physician's fee payment of crippled children's services of the Department of Health to the HMA Fee Survey Committee for study.

ACTION:

It was voted to accept the Crippled Children's Committee's recommendation.

(2) The School Health Committee proposes to reaffirm the HMA stand regarding the immunization clinics and support a total immunization program for the State. The Committee reaffirms the need for a medical home for all children and that "one-shot" clinics are not the answer for a total program. The Department of Health should make available free immunizations for those in need (child health conferences, TB testing) and support the school health program, as the focus for identification and referrals of needs.

ACTION:

It was voted to reaffirm the HMA School Health Committee's stand as proposed.

(3) The Substance Abuse Committee recommends the following: (a) That HMA recommend that every effort be made in the coming year to unify detoxification and methadone maintenance treatment of drug addicts under an administrative organization, and (2) That HMA recommend that the Department of Social Services and Housing, under Title XIX Medicare and Medicaid, pay for medical services rendered to drug dependent persons, with or without medical complications, including detoxification and other such treatments as methadone maintenance.

ACTION:

It was voted to accept the recommendations of the Substance Abuse Committee.

D. Internal Affairs: The Convention Committee reports that the preliminary program for the 118th annual meeting will be in the July issue of the HAWAII MEDICAL JOURNAL. The Committee requests final Council decision on whether or not to have the annual banquet. If the banquet is to be cancelled, the Committee will schedule all business matters such as installation of officers, presentation of awards, and speeches from the HMA and AMA presidents, during the luncheon on Thursday. Also, the Sportsmen's Night Party will then be held on Friday evening rather than Saturday evening if the banquet is cancelled. The Committee recommends that the banquet be cancelled for this year in lieu of the luncheon.

ACTION:

It was voted to not accept the Convention Committee's recommendation but to have the banquet on Friday, November 1, with all business matters scheduled at that time.

E. Cancer Research Center. It was recorded that Lawrence Piette, Ph.D., was named director of the Cancer Center by the University of Hawaii. In a recent communication, prior to Dr. Piette's appointment, the Cancer Center was reminded that the Executive Committee of the Cancer Center should be twelve in number including four representatives from the University of Hawaii, four from the Hawaii Medical Association, two from the American Cancer Society, one from the Hawaii Hospital Association, one from the Department of Health, and the Executive Director of the Research Corporation. At that time the HMA took the position that the Executive Committee should be executive in nature, rather than advisory, to assure strong community participation.

ACTION:

It was voted to reaffirm HMA's previous position on the Executive Committee, but if no pertinent new information is presented regarding its true executive stand, HMA's endorsement will be withdrawn.

F. PSRO: A planning contract of \$77,120 effective June 28, 1974 was awarded the Hawaii Foundation for Medical Care (HFMC). However the Department of Health, Education and Welfare (DHEW), Region IX, mandated the development of a new, free-standing corporation with a primary purpose of assuming functions and responsibilities of a PSRO as outlined in the PSRO Program Manual and the original Request for Proposal. The original proposal provided for an independent organizational set up for PSRO within the HFMC; however, the DHEW felt that this was unacceptable unless a new free-standing corporation was created. In view of this, the Pacific PSRO, Inc. (Pac PSRO) was created and approved by the HFMC Board of Trustees as the vehicle through which PSRO planning and implementation would be accomplished in this area. This administrative change order from DHEW substituted the PacPSRO as the contractor in place of HFMC. DHEW designated the State of Hawaii, Guam, American Samoa, and the Trust Territory of the Pacific Islands into a single PSRO area.

In addition to creating a new corporation for PSRO as requested by DHEW, the PacPSRO has adopted a new set of bylaws. It has developed a plan for organizational membership involving the Osteopathic Association and created a PSRO Advisory Board with representatives from the State Health Department, the State Medicaid Agency, Medicare Fiscal Intermediaries, county medical societies, the Hawaii Medical Association, and the Hawaii Hospital Association. A recruitment mailing was sent to physicians, and to date over 50% have designated HFMC as their representative organization in this PSRO area for implementing PSRO under Public Law 92-603. PacPSRO initiated a plan for acquisition of organizational resources and is planning a

development of PSRO implementation especially in hospitals. A general meeting of representatives from hospitals is planned in Honolulu. It is felt that a site visit to other geographic areas at this time is premature and would prove unproductive.

G. Emergency Medical Service: The previous emergency medical training service under the Department of Transportation, City & County of Honolulu, was terminated as of June 30, 1974. The program was then picked up under DHEW and the RMP grant from July 1, 1974 to October 1, 1974 at which time the cost carried by RMP will also be picked up by DHEW from November 1, 1974 to June 30, 1974. Starting November 1 the grant includes the purchase of two fully equipped ambulances, a \$2,000 communications system for dispatch purposes (not the medicom system), and \$150,000 for the 911 emergency call system for the island of Oahu.

As previously reported a request was submitted to HEW-EMS that the City & County of Honolulu be funded separately from the neighbor island emergency service programs. The City & County emergency service proposal was funded but the neighbor island proposal was not funded as submitted by the Department of Health. It has been suggested that the Department of Health submit a planning grant from January 1, 1975 to June 30, 1975 followed by an implementation grant from July 1975.

Mr. Lot Lau, Deputy Director, resigned as of August 1, 1974. Dr. J. Sims has been employed as the training coordinator.

H. Public Health Issue Papers: Comments or letters of support were requested from the Continuing Education Committee, Legislative Committee and Community Health Committee, and the Bureau of Research and Planning relative to issue papers dealing with licensing and re-examination and the health care delivery system which were received from the Hawaii Public Health Association.

ACTION:

It was voted to approve the submission of positive responses to the issue papers as requested.

I. Bureau of Research and Planning: The Committee met to discuss three of the above issue papers and are of the opinion that the Hawaii Medical Association should develop a policy manual similar to that of the California Medical Association and the American Medical Association.

J. Molokai: Drs. Iaconetti and Reppun, with Mr. Thorson, were sent to Molokai to confer with Molokai physicians and representatives of the Community Action group to initiate efforts to provide better medical services for the people of Molokai. It was learned during that time that the University of Hawaii Medical School is also interested in assisting with the problem. While the HMA is attempting to interest physicians to practice medicine in Molokai, Dr. Frank Tabrah of the University is interested in a program to rotate interns and residents to Molokai with faculty advisors.

K. Waianae Health Center: A grant of \$230,000 was requested by the Waianae Comprehensive Health Center and it appears at this time that HEW will fund the project for this amount. The Board of the Health Center submitted a request to the Governor's office asking that the lease between the Waianae Medical Clinic, which is a private facility, and the State be terminated. Because of the shortage of physicians in that area, the State will continue assistance to the Clinic and the Health Center was instructed to cease further harassment to the Clinic.

L. Tumor Registry: It was reported that the Hawaii Tumor Registry will relocate to new quarters in the Bishop Trust Building sometime in August.

OLD BUSINESS

HMA-HCMS New Quarters Committee: Several meetings have been held with the real estate management firm and property owners regarding the proposed development which will eventually house the HMA-HCMS and its affiliate organizations. The property owners have indicated they are

interested in the project and certain legal steps are underway.

NEW BUSINESS

A. The Hawaii Medical Association has been alerted that a Physician's Action Group has been formed to obtain more equitable payment of services rendered by physicians to patients in the Medicaid program. The Fee Survey Committee will meet further with the PAG and the DSSH regarding this matter.

B. Announcement was made that a five percent deviation in physicians and surgeons professional liability insurance rates through Argonaut Insurance Company became effective July 1, 1974.

C. Long-range Planning: The Council was reminded that the HMA needs to establish definite direction regarding long-range plans as well as determine how HMA will participate in various medical projects. Various programs are being developed in the community requiring physician leadership. Federal funds are being used to establish centers in various cities for various chronic diseases. It is recommended that the medical association take leadership in the many proposed medical programs.

ADJOURNMENT

The meeting adjourned at 10:30 p.m.

R. VARIAN SLOAN, M.D., *Secretary*

Friday, February 14, 1975, 5:30 p.m.

Mabel Smyth Lanai

CALL TO ORDER

The meeting was called to order by President-elect William W.L. Dang. Present were Drs. Winfred Y. Lee, R. Varian Sloan, Grover, H. Batten, Herbert Y.H. Chinn, George Goto, J.I.F. Reppun, Arnold Siemsen, John Edwards, Carl Lum, Ann Catts, Rowlin Lichter, John Kim, Sakae Uehara, Verne Adams, Albert Chun-Hoon, and Marion Hanlon plus Drs. Douglas B. Bell II, Calvin Sia, and William E. Iaconetti.

MINUTES

The minutes of the January 10, 1975, meeting were approved as circulated.

SECRETARY

The report of the secretary was approved as submitted.

REPORT OF THE TREASURER

The financial statement for December 1974 was filed subject to audit.

COMMITTEES AND COMMISSIONS

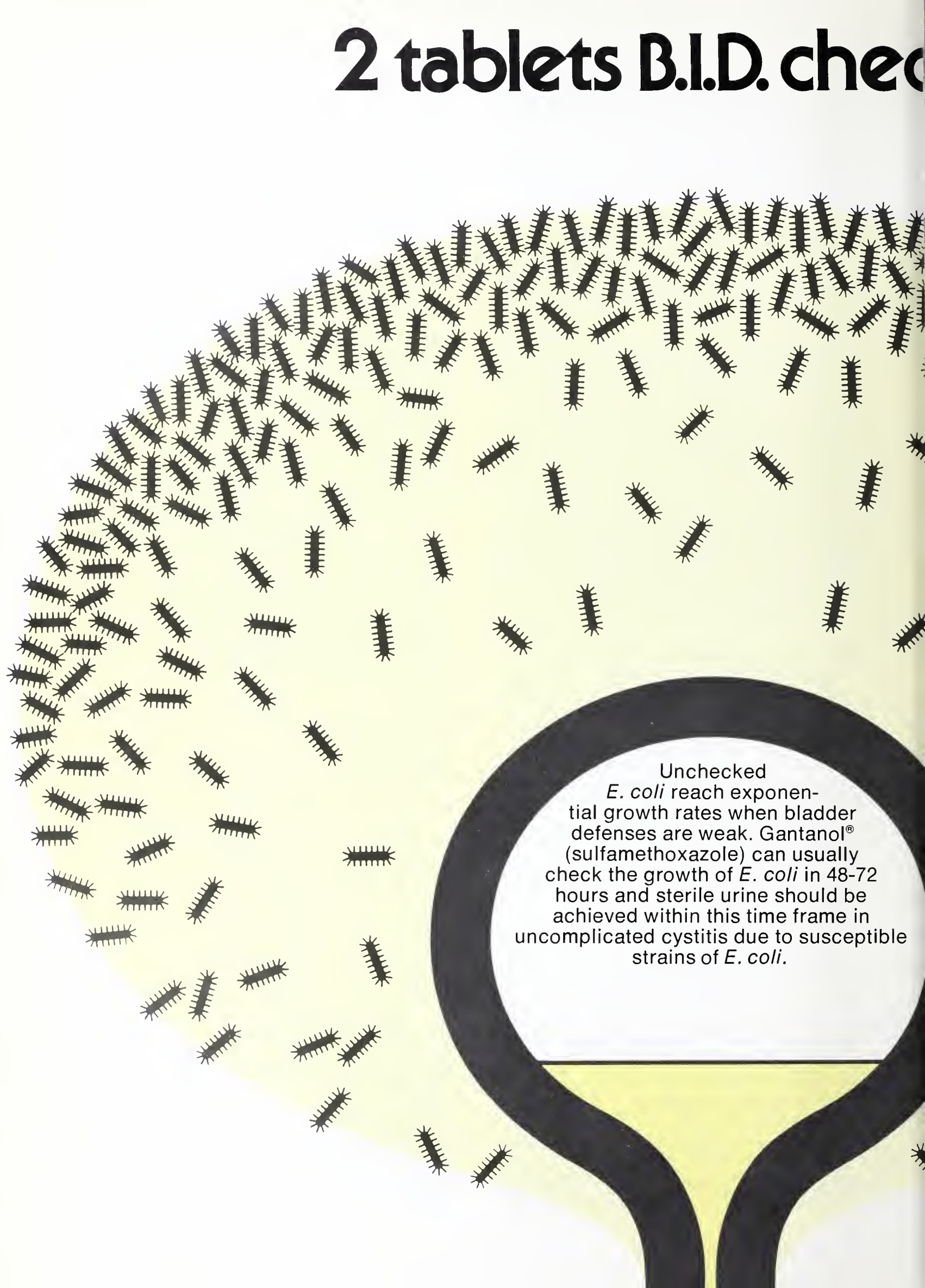
A. Medical Education and Peer Review: The Professional Liability Committee met with the presidents and peer review activity chairmen from each county medical society as well as representatives from Argonaut Insurance Company, the Board of Underwriters, the Department of Regulatory Agencies, and the Legislature to discuss various legislative approaches regarding medical malpractice insurance. Mr. Thorson recommended that certain stop-gap legislation could be introduced immediately such as (a) a pooling plan for casualty carriers (b) some form of pre-trial arbitration and (c) revision to the community immunity law. Some of the long-term proposals might include an advance payments law, measure of damages law, as well as others which might be prepared by the next Legislative Session.

ACTION:

It was voted to proceed as outlined by Mr. Thorson and should any changes occur that they be cleared by the Executive Committee.

Senator Inouye's no-fault malpractice bill was discussed and the President recommended serious attention be given the bill.

2 tablets B.I.D. check



Unchecked
E. coli reach exponential growth rates when bladder defenses are weak. Gantanol® (sulfamethoxazole) can usually check the growth of *E. coli* in 48-72 hours and sterile urine should be achieved within this time frame in uncomplicated cystitis due to susceptible strains of *E. coli*.

exploding counts of E. coli

For acute cystitis*

Gantanol® B.I.D. sulfamethoxazole/Roche®

Basic therapy with convenience:

4 tablets (0.5 Gm each) STAT — then 2 tablets B.I.D.
for 10 to 14 days

*Nonobstructed; due to susceptible strains of *E. coli*

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms. **Note:** Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm b.i.d. or t.i.d. depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs b.i.d. Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.



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Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

B. *Internal Affairs*: Dr. Sloan reported the tentative dates of the House of Delegates meeting and banquet are scheduled for October 24-26.

C. *Health Service and Care*: Legislation has been introduced calling for the establishment of a physician's assistant program at the University of Hawaii School of Medicine. The 1973 HMA House of Delegates recommended that a current assessment of needs and job opportunities be made before embarking on a training program for physician's assistants.

ACTION:

It was voted to reaffirm the position of the House of Delegates.

D. *Medical Services*: A hearing on the proposed regulations and amendments to the Medical Assistance Program (Medicaid) was held on January 14. In view of the overwhelming opposition to the proposal, the administrator of the medical care division agreed to discuss this further with the administration. The Economic Evaluation and Adjustment Committee has met with the Physician's Action Group and testimony has been presented before various committees of the Legislature.

ACTION:

If legislation is introduced relating to physician's services under the Medicaid program, it was voted to circulate this information to the entire HMA membership. It was further voted to prepare an article for the Hawaii Medical Journal on this subject and the Council directed Dr. Chun-Hoon to prepare the article.

E. *Legislation*: Copies of testimony presented before the Legislature were circulated to the Council.

ACTION:

It was voted to prepare an article for the Hawaii Medical Journal on the subject of cancer control and the role of the Hawaii Tumor Registry.

Dr. Lee reported that a meeting had been held with representatives of the Hawaii Pharmaceutical Association. The HMA Pharmacy Committee will continue to meet with representatives of the Pharmaceutical Association. The HPA has also expressed an interest in joining the Hawaii Association of Professions.

F. *PL 93-641*: Four representatives of the HMA attended a meeting in San Francisco to discuss the impact of PL 93-641. Representatives from the Region IX Office of HEW also met with HMA Officers on February 13. Dr. Dang reviewed the plan of action for the State of Hawaii.

ACTION:

It was voted to write to the Governor and to express the willingness of the HMA to participate and cooperate with the liaison officer for the implementation of PL 93-641.

G. *Cancer Commission*: Representatives of the Commission met with Max Myers from the National Cancer Institute while he was in Hawaii for site visits. The present contract with the RCUH has expired. The Cancer Commission has agreed to meet weekly.

H. *PSRO*: Progress reports for December and January were circulated. Dr. Lee reported that the election process for the PSRO Board of Directors has begun.

NEW BUSINESS

A. *Request from St. Francis Hospital*: HMA has been asked to endorse the Home Care Cancer Service Program of St. Francis Hospital.

ACTION:

It was voted to endorse the project.

B. *Invitation from the Department of Health*: The Director of Health has invited professional members of the community, interested individuals, and members of advisory committees to meet with him and the three new deputies of

health at an informal coffee to be held on February 28 from 4:00-6:00 p.m.

C. *Letter regarding unified membership*: The Council was asked to consider bringing before the membership the question of whether unified membership in the AMA, HMA, and county societies should be required. It was noted that any change in membership requirements would require a Bylaws change.

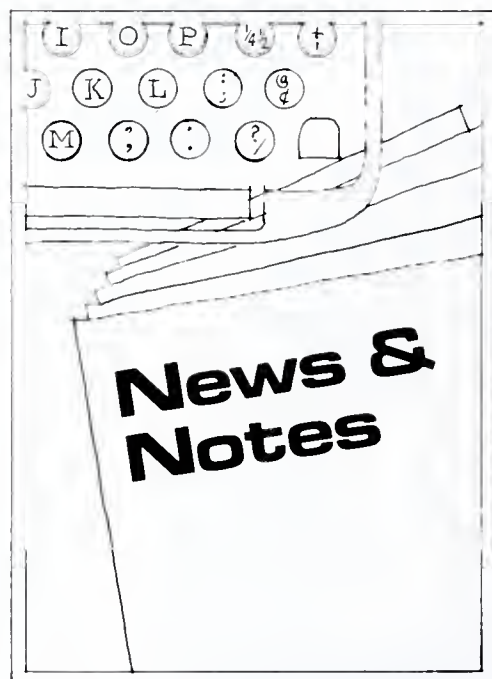
ACTION:

It was voted to respond to this inquiry stating that the Council does not feel that a plebiscite should be taken at this time.

ADJOURNMENT

The meeting adjourned at 11:00 p.m.

R. VARIAN SLOAN, M.D., *Secretary*



HENRY N. YOKOYAMA, M.D.

Life in These Parts

We were pleasantly surprised to learn that **Ike Kawasaki** is vice president of the board at Wo Fat... Since there is a Wong's Okazuya (Japanese delicatessen) in town, it must be all right to have a Japanese on the board of a Chinese restaurant...

One Friday morning, we met **Paul Conduit** making rounds and he quite innocently asked, "Do you know how to keep a moron in suspense?" We asked naively, "How?" He smiled a most beatific smile and left us with the remark, "We'll let you know on Monday..."

Spurred by the recent incident in which an emergency room doctor was not available for a child with abdominal pains, Kona Hospital has now hired a doctor for the weekend duty...

Jon Pegg was project medical officer for the U of H five-man-research team which spent a month-long simulated deep dive experiment off Makapuu in the 70-foot habitat *Aegir*. It seems that the men lost an average of 5 lbs during compression, that body water loss and urine output increased from 50 to 100% initially, then dropped somewhat, that exercise experiments showed that man's maximum work capacity is not affected, that the heartbeat slowed down for the first 3 or 4 days, then returned to normal, that social problems during the long confinement were minimal, that lack of sleep because of the heat was one of the biggest problems, that voice distortions from the helium environment forced the men to use hand language and written notes, and that there was some change in hearing capacity...

In April, Hawaii County reported that their emergency medical system was put to the test twice, on coronary patients once in Ka'u and once in Kohala...

Maui health officer **Alice Broadhurst** was asked if the restaurant grading system would hurt "mom and pop" eateries and favor their larger competitors. Alice replied with a resounding "no!" She said, "We won't discriminate... Our job is to keep these restaurants in operation... We are not punitive here... Ninety percent of the troubles in our restaurants can be solved with hot water, soap, Brillo pads and elbow grease."

John Milnor recently unveiled a portrait of his late father Guy Milnor, one of the founders of the Straub Clinic. Now the four portraits of Straub partners by Patric are complete...

The John A. Burns School of Medicine is expected to graduate the first class of 62 students on May 18. It was fortunate that the Board of Regents met on Kauai in April and approved the awarding of the degree of Doctor of Medicine...

A 1970 Legislative Reference Bureau Report reported that 26 boards and commissions were made up entirely of members of that profession. There was talk of naming more lay members to them because of evidence that many licensing boards exercise their power in many ways not in the interest of buyers. **Tom Thorson**, our HMA executive director, was firm: "What in the name of heaven would a lay member use for methodology in trying to determine the professionalism of a candidate for a physician's license?"

When Rep Buddy Soares requested the Health Dept to conduct a feasibility study for a hospital or an advanced emergency medical care center in Hawaii Kai because the Hawaii Kai population alone is expected to reach 60,000 by 1980, **Audrey Mertz**, deputy director, spoke in favor of Rep Soares's resolution with these reservations: "The Health Dept studies show that there is no need at the present time for additional hospital beds anywhere on the Island of Oahu... especially now that the law requires the obtaining of a certificate of need from the State Comprehensive Health Planning Agency before a hospital can be built... Regarding an advanced emergency medical care center... there are mixed reactions... The City and County of Honolulu offers ambulance service to Hawaii Kai from its Aina Haina station on a daily basis and from Wailupe on weekends..."

Tom Thorson's Corner

Tom says the malpractice insurance situation reminds him of an Amos and Andy joke. "Amos sez, 'Andy, I got me a subpoena.' 'Amos, what's a subpoena?' 'Well Andy, you gotta get to the Latin root of the word. Sub means under... and you know what Poena is... So put it together and it means, 'They got you by the you know what...'"

A missionary was trying to teach a native English as they walked through the African countryside. He pointed to a tree and said, "Tree." The native repeated, "Tree." They saw a snake. He said, "Snake." The native repeated, "Snake." They chanced upon a couple making love in the brush... The missionary judiciously said, "Riding bike." The native forthwith drew out his blow gun and shot them both dead with poison darts... The missionary was aghast... "Why?" "My bike," was the firm reply...

Bulletins

The WPA (World Psychiatric Association), which meets once every 5 years and is based in London, is holding its next international meeting in Hawaii in August, 1977. **George Schnack**, arrangements committee member, says about 7,000 psychiatrists are expected. The last meeting, in Mexico City in 1972, was attended by 5,000...

Professional Moves

In March, **Ben Lambiotte** opened his office at 407 Uluniu Street, Kailua, in Consulting Practice of Preventive Medi-

cine (in Design, Development, Operation & Management of Health & Related Human Services). A block away, allergist **Philip H.K. Kuo** opened at 419 Uluniu St. GP **Joseph Hennessey Jr** joined the Kaiser Medical Center at 1697 Ala Moana Boulevard, and Straub gastroenterologist **W. Dawson Durden Jr** relocated to Suite 1317, Pan Am Building. **Richard Cardines**, our oft-quoted Kauai health officer for the past 5½ years, resigned. Richard will leave for more romantic vistas, viz Tahiti, where many years ago, he met and fell in love with a beautiful Tahitian maiden while serving as a medical missionary aboard the world cruising brigantine *Yankee*...

Elected, Honored & Appointed

The Hawaii County Council approved a resolution honoring **William Bergin** for his many contributions to the Big Island in medicine and community service... The Kauai unit of the American Lung Association recognized **Peter Kim** for his 25 years of service with a plaque and commendation at its recent 46th Annual Meeting... Our tennis playing surgeon, **Ben Tom**, was elected chief of staff at Queen's for the next two years, giving outgoing Chief of Staff **Unoji Goto** a much deserved respite... **Bill Sage** is the chief of staff elect...

Miscellany

An old gentleman was known as the wisest man in town. A little boy was curious, "How did you get so wise?" "Well, son," he replied sagely, "Wisdom comes from good judgment... Good judgment comes from experience... And experience comes from bad judgment." (As told by Joan Hodgman)

Conference Notes

Our visiting surgical professor with the golden tongue, **Ben Eisman**, spoke on MOF (Multiple Organ Failure) and we managed to scribble the following "purple prose" therefrom:

"Failure begets failure... Prognosis diminishes like a cascade as failure starts... The original sin is usually a technical error... This starts the MOF debacle... The whole thing began when someone screwed up in the OR..."

The initiating factors are technical error (12/26), shock (2/26), and sepsis (15/26) The domino effect in MOF—organs topple sequentially... eg, hepato-renal syndrome

Bacterial sepsis is frequently the subtle cause of hepatic, renal, and pulmonary failures...

The clinical manifestations of MOF are: uremia, jaundice—hepatic failure, respiratory distress syndrome—hypoxia, cardiac failure, confusion-coma, and stress ulcers. They usually occur 48-72 hours postop... Then you begin to get the dwindles... As the patient worsens, the number of diagnostic and monitoring devices increases...

Treatment of MOF: 1. Most frequently, drainage of an abscess... 2. Don't do anything wrong ie, without prima facie evidence...

Prevention of MOF: 1. Avoid sepsis—intra-abdominal pus is difficult to localize... 2. Restore blood volume... 3. Restore fluid volume and electrolyte concentration... 4. Optimize cardiac function with digitalis and diuretics...

There is an economic and moral problem involved in MOF... The cost of the average 17-day ICU stay is \$10,000 for fatal cases... and salt-poor albumin is \$52... The issue then becomes what to do beyond the point of no return...

Oncology Dialogue

A 44-year-old Japanese woman was explored and found to have carcinoma of the colon with liver metastasis. Radiolo-

"Antiacid" action for ulcer patients...

one of the many things you need in an anticholinergic.



Pro-Banthine is considered adjunctive in total peptic ulcer therapy that may include diet, conventional antacids, bed rest, and other supportive measures.

Pro-Banthine is provided in several different dosage forms which will meet virtually any clinical need. It is just as versatile in filling patient needs, among which are:

"Antiacid" action — Pro-Banthine® (propantheline bromide) reduces gastric secretory volume and resting total and free acid.

"Analgesic" action — Pro-Banthine helps to control the acid-spasm-pain complex.

Vigorous anticholinergic action — Pro-Banthine® Vials, 30 mg., are for intramuscular or intravenous use when prompt and vigorous anticholinergic action is required.

Mild anticholinergic action — Pro-Banthine® Half Strength, 7.5 mg. tablets, for more exact adjustment of maintenance dosage in mild to moderate gastrointestinal disorders.

Pro-Banthine® (propantheline bromide)

a good
option
in peptic
ulcer



Pro-Banthine®

brand of
propantheline bromide

Indications: Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control.

For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

SEARLE

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gist **Ed Childs** chided the intern: "In your presentation you said the patient was 'subjected' to a liver scan. You should say the patient was 'treated' to a liver scan." Pathologist **Grant Stemmerman** alluded to the reported etiological factors for colon cancer: "Perhaps the patient ate too much meat and string beans." Proctologist **Dick Omura** asked, "Why wasn't the primary tumor removed?" Stemmy commented, "I've been hearing this for the past 2 or 3 years. The reason for removal of the primary tumor even with obvious metastasis is so chemotherapy will be effective. What evidence is there that debulking is good for chemotherapy?"

A 70-year-old Japanese man with a 2-week history of hematuria was found to have transitional cell carcinoma of the bladder on cysto and biopsy. Moderator **Noboru Oishi** turned to surgeon **Shoyei Yamauchi**. Shoyei recommended: "I would do lymphangiography first . . . Then explore and do a partial resection . . . How bad is the tumor? How anaplastic?" Stemmy replied, "Not too anaplastic" . . . Radiotherapist **Ed Quinlan** offered, "When the tumor is undifferentiated, but discrete and there is no obstruction, preop radiation has a place." Medical education director **Ray Huffman** inquired, "What would grading do? For example, what is Grade I?" Stemmy: "Grade I would be a superficial papillary carcinoma. There would be no need for more than fulguration." **Carl Boyer** explained, further, "Staging correlates with differentiation . . . The higher the degree of undifferentiation, the higher the stage. In Stages B & C, preop radiation raises the 5 year survival . . . Clinical evaluation is a lousy way to stage bladder carcinoma . . . Surgical exploration is the only way." Noboru turned to chemotherapist **Quint Uy**: "Any place for cytotoxic drugs in bladder tumor?" Quint smirked only. Noboru: "Guess that answers the question." Stemmy added the coup de grace with: "So far Bleomycin has done more damage than good . . . It causes horrible looking lungs." Noboru was defensive: "Perhaps we should use smaller doses."

Letters to the Editors

S. G. Ross writes: "The medical school in Hawaii is a luxury. The State can't afford the school, unless it decides to go bankrupt. It would be cheaper to subsidize those who want to be physicians to go to medical schools on the mainland." (*Ed. Whoever S.G. Ross is, he is apparently a non-member, and is not presently a practicing physician.*)

When **Sharon Bintliff** argued in favor of S.B. 654 and H.B. 248 for immunization of children by the government, **Fred Reppun** pointed out that (1) "99.99% of the school kids have been immunized without new laws," that (2) "if either bill becomes law, it would be one more detriment to parental responsibility," that (3) "DOH immunizations in school will subvert the annual physical exam," that (4) "it makes no sense to provide 'free' service to those who can afford to pay for it (smoking cigarettes, one pack per day, costs \$15 to \$18 per month.)", that (5) "legislation is no substitute for education and that '6' 'education of every child and adult in things medical is what the people of our society need most . . . legislation to this end would be much more worthwhile."

When an *Advertiser* editorial advocated national health insurance (4/17), ex-HMA prexy **Tom Frissell** vituperated: "The U.S. Government has satisfactorily demonstrated its incompetence at running post office, railroads, or what have you. Proper medical care it will destroy completely . . . The advocacy of such policies as NHI shows the bankruptcy of economic thought entertained by its advocates, including the AMA . . . The cause of our economic woes can be attributed only to government intervention . . . Various polls I have seen indicate a good majority of the population is satisfied with medicine as currently practiced . . . Legislation altering that then would not have the approval of the electorate . . . History does repeat itself—and if the public permits further socialization of the country by its government, it can expect only Stalin, Mao, or that ilk as its rulers in the near future—control of medicine is only one step in an increasing burden of serfdom placed on a formerly free people."

Miscellany

A missionary in Africa was confronted by a charging lion with no possible escape . . . "This is the end," he surmised and got down on his knees to pray. He expected to be mauled any second, but minutes passed and still no end . . . He timidly opened one eye and found the lion also praying with front paws uplifted. "I'm so glad to see a Christian lion," sighed the missionary with relief. But the lion was not very encouraging . . . "I'm just saying grace . . ." (As told by Irene Wong)

Monsignor O'Malley called the Pope. "I have good and bad news. Christ appeared before me last night and said he was coming to earth." The Pope was pleased, "That's marvelous! How can such a revelation be bad?" "He wants us to meet Him in Salt Lake City . . ." (Harry Arnold, Jr)

Hors De Combat

From Tom Horton's column we gleaned the following item. "Dr Maurice L. Silver, the Honolulu neurosurgeon who was acquitted after two trials on tax evasion and filed a \$1.5 million lawsuit of his own against three local hospitals, is now quietly practicing in Beverly Hills . . ."

Al Chun Hoon, Alan Pavel and Tom Thorson will represent the medical profession in Insurance Commissioner Clifford Miyoi's committee to solve the malpractice situation: The horrendous tasks they face are: (1) The factor of contingency fees which attorneys charge to prosecute on a client's behalf; (2) A doctrine of "Informed consent" that can be accepted by the courts on a uniform basis; (3) The issue of limited liability; (4) Institution of a malpractice awards commission that will evaluate awards; (5) Binding arbitration which will cut court costs now levied in malpractice cases. It seems that outlays run so high that a person who wins an award in a malpractice case gets only 16% of the amount awarded.

The State was sued for \$1 million by the parents of 19 year old Michael Figueroa, who suffered serious brain damage when he tried to hang himself at the Hawaii Youth Correctional Facilities isolation unit in 1972. A houseparent testified that staffers beat the residents. Psychiatrist Douglas Schramel, who has spent an average of 10 hours a week since 1971, testified, "I don't think there is a cruel person that I have observed . . . They go out of their way to help the boys . . . I've never seen a staff member lay a hand on the kids. But," he admitted frankly, "I've come close to punching some of them myself . . ."

A Star-Bulletin editorial was for once sympathetic to the doctor's lot: "Except for the clergy, if any profession is expected to place the needs of society above its personal requirements, it is the medical profession . . . Moreover, doctors are generally better paid than other people . . . The New York interns and resident doctors were seeking shorter hours—by which they meant a maximum of 80 hours a week!

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They claimed that they frequently had to work 100 hours a week. They said they sometimes worked 50 hours at a stretch... The medical profession's interns and residents occupy a position analogous to the apprentice of the medieval crafts. In other fields, the lot of the apprentice is much improved... nobody is working 100 hours a week... There is a point to making medical internship a strenuous, challenging experience in preparation for the crises that a doctor must confront throughout his career. And it is important that the profession's spirit of dedication and self sacrifice be preserved. Yet internship and residency need not be exhausting ordeals, and it would seem to be in the patient's interest that they not be..."

Someone at Star Bulletin likes us, for 3 days later there was yet another editorial: "Medical malpractice damage suits are soaring. So are awards. So are insurance costs. And so, as a result, are overall medical costs for the public... We suspect that the same thing is happening in the medical area that happened in the automobile injury area, the thing that helped fuel the drive for no-fault auto insurance... A few flagrant cases are probably winning outsides, headline-grabbing awards, while many other cases are getting less than fair adjudication... No-fault auto insurance aims to separate compensation from punishment. Its theory is to compensate all losses without assessing blame, and to punish the wrong-doer through separate criminal processes. The transferability of this idea to the field of medicine ought to be studied... Other proposals suggest State arbitration panels to handle malpractice cases, or tighter controls on the insurance companies that now are either jacking up their malpractice rates fantastically or getting out of the business entirely..."

Perhaps this editorial had some impact, for in April the State Legislature sent a bill to the Governor that would make Hawaii among the first states in the nation to institute a contingency plan for medical malpractice insurance. The measure would empower the State insurance commissioner to invoke a joint underwriting arrangement if malpractice insurance is not reasonably and readily available from commercial insurers. (Similar federal legislation is pending in Congress.) The plan, which would require the participation of all insurance companies writing casualty insurance, would be activated in the event hospitals and physicians cannot reasonably and readily obtain malpractice insurance from commercial companies and would resemble the State's no-fault automobile insurance law...

Surgeon **Judson McNamara**, who operated on a man shot three times by police with dum-dum bullets, has a personal bias about the bullets. "I have always felt that a bullet which is outlawed in international warfare and is illegal in some states for hunting animals should not be used against people."

The Richard Street YWCA will discontinue swimming lessons for children under the age of 3. **Cal Sia**, Hawaii chapter chairman of the American Academy of Pediatrics pointed out that besides the danger of drowning engendered by their lack of fear of water, there are two other hazards. "Bluntly, they aren't toilet trained. This creates a polluted swimming pool... Furthermore a small child will swallow

quantities of pool water which may later cause diarrhea..."

We excerpt from the *Catholic Herald* the following physician testimonies at the Senate Judiciary Committee hearings in March, one for and one against the resolutions backing an amendment for life to the US Constitution. Pediatrician **Herbert Nakata** stated: "After World War II, the American medical profession participated with the World Medical Association to recommit medicine to the rights of the living. Concerning abortion, they reaffirmed the physician's obligation to 'maintain the utmost respect for human life from the time of conception.' With these Senate resolutions I hope that the legislative branch of our government with the help of the medical profession will answer Justice Blackmun when he asserted, 'We need not resolve the difficult question of when life begins.'"

OB man **George Goto**, said his piece: "The amendment would, however, make abortion once again the dangerous, discriminatory, degrading, and expensive procedure it used to be, and abortions would once again be performed without medical supervision in the second and third trimesters of pregnancy and without established government guidelines. As a consequence, the acute care hospitals of Hawaii and throughout the US would once again be flood with seriously and critically ill women. Many of these women will die and will once again increase the maternal mortality rate resulting from these abortions to nearly 50% of all deaths resulting from pregnancy."



Wahiawa General Hospital

Richard P. Tesoro, M.D., Secretary of the Wahiawa General Hospital and reporter for the HAWAII MEDICAL JOURNAL announced the 1975 officers of the Medical Staff:

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 Rodman B. Miller, M.D., Chairman, Dept. of Family Practice
 Gerald Y. Yorioka, M.D., Chairman, Ad-Hoc Committee on Medical Staff By-laws
 Manuel A. Abundo, Jr., M.D., Chairman, Emergency Room Committee
 J. T. Lucas, Jr., M.D., Chairman, Patient Care/Rehabilitation Committee
 Buenaventura Realica, M.D., Chairman, Medical Records Committee
 Daniel Whang, M.D., Chairman, Pharmacy & Therapeutics Committee
 Richard P. Tesoro, M.D., Chairman ICU/CCU Committee
 Rodman B. Miller, M.D., Chairman CPR Committee
 Gerald Yorioka, M.D., Chairman Pulmonary Therapy Committee
 Buenaventura Realica, M.D., Chairman, Utilization Review/PSRO Committee
 Richard P. Tesoro, M.D., Chairman, Continuing Medical Education Committee and
 Norberto Baysa, M.D., Chairman, Library Committee

The Annual Wahiawa General Hospital Invitational Golf Tournament will be held on May 15, 1975. Last year's winner was Daniel Whang, M.D.

Wahiawa General Hospital Expansion Program

How—When—Where—And Why

The Wahiawa General Hospital was born as a result of World War II. On December 8, 1941, the Army took over Wahiawa Elementary School and set up an emergency hospital in anticipation of war-time injuries. The hospital continued to function as a service to the Army as well as to the general public until 1944, when a group of citizens took it over. The Army was set to close it until the group formed a corporation to operate the facility for the benefit of the people of Wahiawa, including Central Oahu.

Renovations and expansion were needed, but had to be put off until a later date. Thus, in 1958, the present acute facility was built with the Skilled Nursing Facility following in 1968. These two units have been serving under an increasingly heavy demand ever since. Since 1969 the Board of Directors has been working on the problems which attend the plans to raise funds, plan the necessary facilities to be renovated or replaced, the new facilities to be added, and just where all this is to be placed so as to afford the best use of the entire hospital to render the best possible patient care, to both in-patient and out-patient members of the community.

The Board of Directors now feels that the plans as approved will do the best possible job for the time being. These plans call for the addition of one story directly to the rear of the present building covering the entire doctors' parking lot. This addition will allow for the expansion and enlargement of the Emergency Room, the Medical Records and Library unit, the Laboratory and Pathologist's office, as well as the expansion of the Radiology Department. These facilities will all be complimented by having adequate waiting rooms so that the halls will be free for the movement of patients to and from and other uses for which halls were invented. Basic steps will be taken for the eventual inclusion of nuclear medical facilities. Renovations to improve the laundry, purchasing and warehousing operations are included in the plans which will be submitted to bid proposals within the next two weeks. These changes will necessitate

changes in the present space arrangements to move the Business Office and Snack Bar into newly created areas or into those areas formerly used for the Emergency Room and Medical Records and Library. The Snack Bar as such, will disappear into a newly arranged dining room facility, which will be very much more comfortable as well as practical.

The Board of Directors presently guesstimates the completion, of this part of the plans, will take place by the end of 1976. It is hoped that another phase in the expansion of the Hospital can be started soon thereafter. This phase is being talked of as a second story, atop the new addition, which will allow for the addition of new beds, each in its own room, enlarged and expanded ICU/CCU facilities. This expansion will then allow for the renovation of many of the present rooms. We hope at that time to include recreational areas, as well as enlarged and expanded Business Office space.

Kauikeolani Children's Hospital

Dr. Robert Wiebe, Director of Ambulatory Services, has been appointed reporter for the HAWAII MEDICAL JOURNAL, announced A. B. Ho Yee, Chief of Staff, Kauikeolani Children's Hospital.

Kaiser Medical Center

John H. C. Kim, M.D., Chief, Department of Medicine, has appointed Dr. Azucena Ignacio as the HAWAII MEDICAL JOURNAL reporter for the Kaiser Medical Center in Honolulu.

Queen's Medical Center

Dr. Benjamin Tom, Chief of Staff, will be Queen's reporter for the HAWAII MEDICAL JOURNAL and Queen's representative as a member of the HMA Health Facilities Committee, according to Will J. Henderson, Executive Director.

Queen's is expecting to have a full-time Pediatric resident starting July 1, in cooperation with the University of Hawaii School of Medicine Department of Pediatrics.

Dr. Ed Chesne announced the Integrated Program in Internal Medicine in cooperation with the U.H. School of Medicine.

Dr. Deborah Putnam, head of the Emergency Room Physicians group at Queen's, numbering seven doctors, has stated that the ER physicians would like to be in a department of their own. They are at present included in the General Practice Department. There is no means at present for the ER doctors to become active staff members at Queen's, because the present by-laws require that a doctor admit patients in order to acquire active status. Although the ER doctors, by the nature of their work, do *not* admit patients, they saw about 27,000 patients in 1974 at Queen's.

The Queen's ER group hopes to have some board certified members in 1976, when the first board exam in emergency medicine is scheduled.

The parking strain will let up a bit, hopefully, when 800 new parking stalls are opened up in about one year (mid 1976), upon completion of that portion of the building now under construction. Offices for about 100 physicians, in the same building, mauka of the present hospital, should be ready in about 18 months, according to Will Henderson. With the completion of a projected \$6 million cancer center and a new Liho tower, all the Queen's facilities will be valued at about \$36 million.

Maui Memorial Hospital

William C. James, M.D., as incoming Chief of Staff of Maui Memorial Hospital, announced the appointment as reporter to the HAWAII MEDICAL JOURNAL of Dr. J. Mark B. Sowers.

Hale Mohalu Hospital

Andrew P. Sackett, M.D., Medical Administrator of Hale Mohalu in Pearl City, will serve as reporter for the HAWAII MEDICAL JOURNAL.

Saint Francis Hospital

Dr. Lawrence Wong, Chief of Staff, will represent the Medical Staff of St. Francis Hospital on the HMA Health Facilities Committee.

To improve communications, Walter W.Y. Chang, M.D. has been appointed to represent the Medical Staff in reporting to the HAWAII MEDICAL JOURNAL, with assistance from Dr. H.H. Chum.

Shriners Hospital

Ivar J. Larsen, M.D., has been assigned from Shriners Hospital to supply input to the bulletin section of the HAWAII MEDICAL JOURNAL.

G.N. Wilcox Memorial Hospital & Health Center

At the direction of Dr. Peter Kim, Chief of Staff, Mrs. Edna Stoffel has been appointed to report for the G.N. Wilcox Memorial Hospital and Health Center.

Castle Memorial Hospital

The officers of the Medical-Dental Staff for 1975 are: Roger Brault M.D., Chief of Staff, Howard Keller M.D., Vice-chief of Staff, John Pearson M.D., Secretary.

The MedExeCom is made up of these three elected officers, plus the chiefs of departments: Edwin Dierdorff M.D., Surgery; Philip Foti M.D., Medicine; Fred Reppun M.D., Family Practice; Hamilton Winston M.D., Ob-Gyn; Bob Simmons M.D., Emergency Medicine. Ex-officio members are Larry Larrabee, Administrator, and Mrs. Rosalind Chang, R.N., Director of Nursing Service. The MedExeCom meets every third Tuesday at 5:30 PM.

The standing committees of the Medical-Dental Staff and their chairpersons are: Credentials: Harold Lawson, M.D.; Utilization Review and Medical Records: Howard Keller, M.D.; Tissue and Infection: Adelina Matsui, M.D.; By-laws: Fred Reppun, M.D.; Disaster: James Budde, M.D.; Pharmacy: Winfred Chang, M.D.; Continuing Medical Education: Herbert Uemura, M.D.

The meetings of MedExeCom have been graced by the presence of one or more members of the hospital's Board of Trustees. Reciprocally, the Chief of Staff sits with the Board when it has its meeting.

The Robert Wood Johnson Foundation is an independent philanthropy, interested in improving health care in the United States.

It was established in 1936 and became national in scope in 1971. By December 31, 1973, it had had two years of experience in moving towards its objective of "making health care more fully available to non-hospitalized Americans." Its annual report for 1973 states: "Our experience to-date has strengthened our conviction that the lack of a dependable system of ambulatory front-line medical care represents the most pressing problem in health immediately confronting the American people."

We don't know how it is with the rest of the nation, but here in Hawaii we think this premise is untenable. Although the report goes on to say that these things have "been lost which must be restored..."

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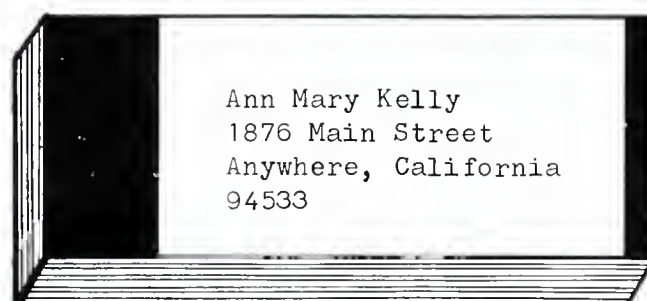
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and who can bring both personal support and
science-based medical expertise to bear on
our problems."

The Foundation is convinced that the future lies in the development of group practices and "is supporting programs which are developing team practice settings staffed by combinations of primary physicians and other health professionals with strong linkages to larger, more complex medical care organizations." The report continues: "The Foundation is supporting a few independent non-profit organizations to cover the development and start-up costs needed to establish new group primary care practices in areas now without adequate health coverage."

Specifically, the Foundation has offered Castle Memorial Hospital and its Medical/Dental Staff the opportunity "to plan and initiate a primary care group practice."

Of 6,000 some odd community hospitals, 900 were screened and 60 community hospitals, one or more in each of 50 states, were chosen as being eligible for a grant of \$500,000 each, to cover a four-year period 1976 to 1979 as a one-time award. Castle Hospital is one of these 60. The award is for start-up and development, with the hope that the private "HMO" (as we see it) will become self-sufficient by then. The group must have at least three full-time primary physicians, a full-time administrator, and paramedical associates, bound to the hospital by a contract for the purpose of sharing expenses and income. Adequate facilities for this group must be provided, but none of the award is to be used for capital improvements.

The Medical Executive Committee of Castle Memorial Hospital considered the proposal carefully. It formulated a reply to James Block, M.D., Director of the National Planning Association, to whom this project was given to administer. The Medical/Dental staff at its quarterly meeting on January 17, 1975 approved the stand of the Medical Executive Committee, and authorized Roger Brault, M.D., Chief of Staff, to forward the reply, a copy of which follows.

J.I. Frederick Reppun, M.D.

James Block, M.D., Director
Primary Care Group Practice Program
1625 Massachusetts Avenue, N.W.
Washington, D.C. 20036

Dear Dr. Block:

This is in answer to communications from David Rogers, M.D., dated November 15, 1974, and addressed to the administrator and the Chief of the Medical Staff of this hospital regarding our eligibility for grants from the Robert Wood Johnson Foundation.

We are a community hospital sponsored and underwritten by the Seventh-day Adventist church and serving a stretch of coastline some 15 miles in either direction from the hospital. The hospital is well equipped as an acute care facility for medicine, surgery and obstetrics with limited facilities in pediatrics (a pediatric center and hospital is only 10 miles away across the Koolau range of mountains). It also has some 40 beds in a Skilled Nursing facility on one floor. It is fully equipped in radiology, including angiography, laboratory, inhalation therapy, physical therapy. It has a modern intensive care unit. It plans to have limited nuclear medicine facilities. It has no resident house staff.

The emergency room is fully equipped for emergencies of all types and it is serviced by a group of private physicians in such a way that there is a physician-in-residence 24 hours

a day, seven days a week. These physicians provide episodic care, but are geared into a system of referral to in- and out-patient care by the physicians in the community. In this way, episodic care is readily converted into permanent or semi-permanent primary and secondary care, with a freedom on the part of the patient as to whether to accept or reject such referral. The arrangement has led to intense satisfaction on the part of the physicians of the community, particularly those who are on the hospital's medical staff, and has been so well accepted by the community that people almost automatically go to the hospital's emergency room after office hours and on weekends and holidays without breaking their regular attachments to their usual sources of primary care. We have good ambulance service and expect to get helicopter service soon.

There are some 50 physicians in the community served by this hospital. They are in groups of 15 all the way down to solo, and there is no problem in terms of obtaining the highest quality of specialist care by consultation with those who practice in the large clinics, medical centers and major hospitals of Honolulu. We are, in fact, a loose association of Castle Hospital-based primary and secondary care physicians with much greater freedom of consultation and referral than any HMO could provide.

- 1. We have two areas in particular in which it has been difficult to establish a primary care office—either for a solo physician or for a small group or satellite. These areas—Waimanalo, which is some 5 miles distant from the hospital in an easterly direction, and Kahaluu, which is 12 miles distant in the opposite direction—are actually not that far away from medical/dental service, but are separate and distinct communities.*
- 2. The employment of physician-extenders, nurse-practitioners, and social workers, etc., adds to the costs of health care, whether these allied health professionals are available for service on an individual fee-for-service basis or whether employed by groups or by a hospital, or by an HMO. These kinds of desirable services might be provided by tax money, but taxes, too, come out of the consumer's pocket.*
- 3. The same can be said of health education and of peer review—desirable but expensive in the long run. Peer review in the sense of continuing medical education is already an entity within the medical profession and is a truly "free" service. Education-in-health of the general public is highly desirable but if offered by existing primary care physicians' offices it will take them away from the care of the sick and injured, which consumes perhaps 60% of a physician's office time; it also takes the physician away from the other 40% of his patients—those that need and get health maintenance or "preventicare." This, too, can best be financed by government, primarily via the school system from grade 1 to 12 and beyond.*
- 4. There are serious deficiencies in the financial coverage of health care, despite the very wide use of pre-paid insurance. Medical catastrophes to the pocketbook need to be financed somehow. An HMO cannot do it alone. Federal insurance can and should do so. Medicare and Medicaid are grossly inadequate to the need. They should be geared to real "need." Centralizing facilities and services, sharing expenses, billing and keeping common records will not reduce medical costs a great deal; the more available the services, the greater will be the demand. The only answer to this is "individual fiscal responsibility," with planned deductibles and co-insurance. Education-in-health as mentioned in 3. above should become a very large factor in reducing usage of the most expensive services and facilities.*

In summary, it seems as if this community is already well served. Therefore, your kind invitation to become a private HMO is declined.

Sincerely yours,

Roger Brault, M.D., Chief of Staff
For the Medical Staff

JUNE, 1975
VOL. 34 NO. 6

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This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Indications: *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension.* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium fre-

quently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy

patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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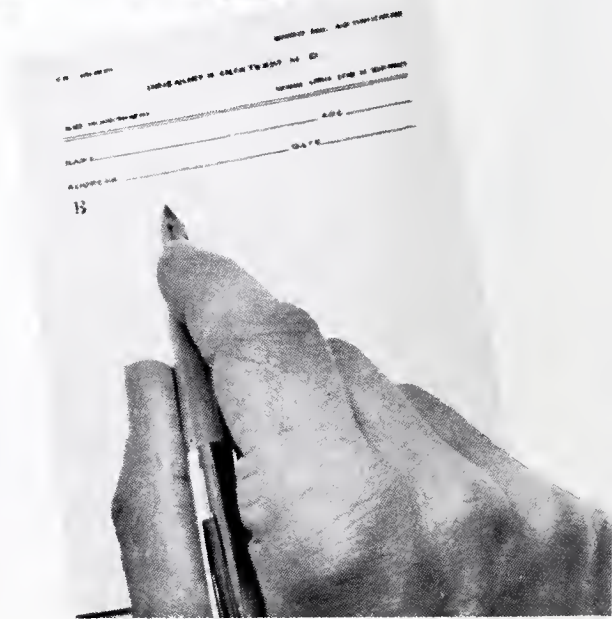
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Bioequivalence



the weight of scientific opinion:

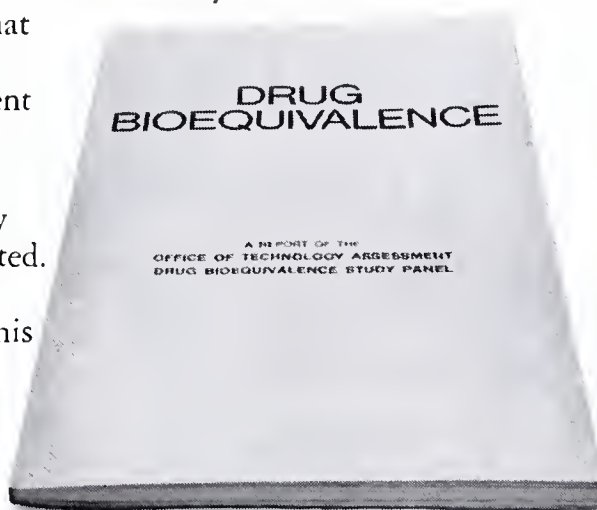
If the pharmacist substituted a chemically equivalent drug for the one you have specified for your patient—could you be certain of that product's safety and effectiveness simply because the chemical content was the same?

Definitely not, unless bioequivalence tests and other quality assurance checks had been conducted. The pharmaceutical industry and many scientists have maintained this position for years, but others have questioned it. Now the Office of Technology Assessment of the Congress of the United States has reported on the issue in its Drug Bioequivalence Study.*

Here are a few definitive statements in the O.T.A. report:

"...the problem of bioinequivalence in chemically equivalent products is a real one. Since the studies in which lack of bioequivalence was demonstrated involved marketed products that met current compendial standards, these documented instances constitute unequivocal evidence that neither the present standards for testing the finished product nor the specifications for materials, manufacturing process, and controls are adequate to ensure

that ostensibly equivalent drug products are, in fact, equivalent in bioavailability.



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The Pharmaceutical Manufacturers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical products, subject to new drug procedures, to document:

(a) chemical equivalence; and

(b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or (c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual inspections and certification thereafter, and strict adherence to FDA regulations on good manufacturing practices.

The overall quality of the United States drug supply is excellent. But only a total quality assurance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription...



Pharmaceutical Manufacturers Association
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*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

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Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control.

For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

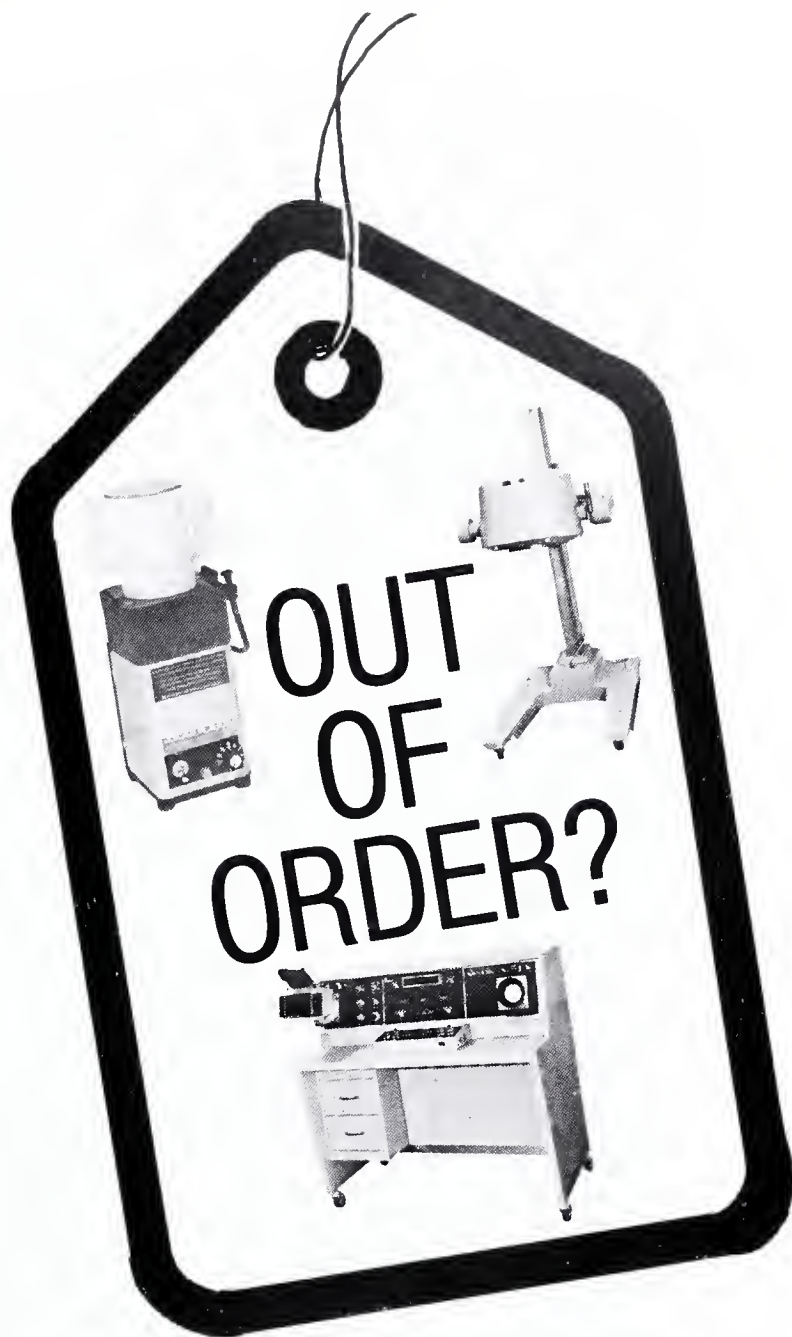
Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

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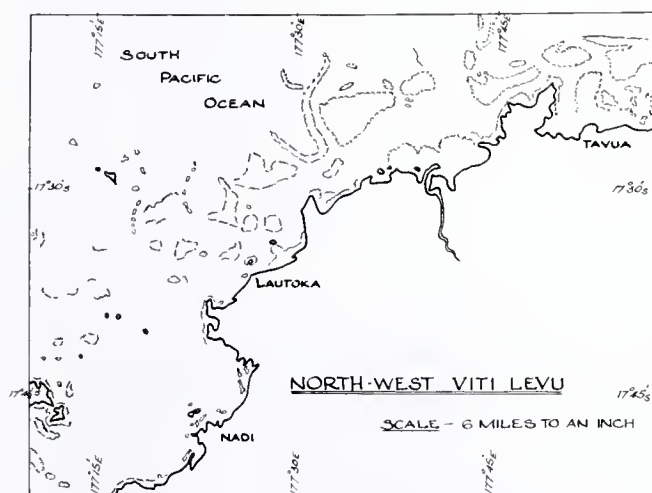
Ciguatera Poisoning in North-West Viti Levu, Fiji Islands

MICHAEL SOROKIN, M.B., B.Ch; M.R.C.P.*, *Lautoka, Fiji.*

Ciguatera disease is prevalent in the Caribbean and in the islands of the Western Pacific from Hawaii to Australia's Great Barrier Reef. Fish poisoning of the ciguatera type is known to occur in Fiji, and an unpublished survey by Mrs. Jane Cooper was quoted by Banner and Helfrich in 1964.¹ They also added their own information to a compilation of the toxic fish and toxic areas in the Fiji group. No other published information is available. This note gives some account of the problem as seen in north-west Viti Levu.

The Fiji group of some 300 islands straddles the 180° meridian at 15°-22° South. Viti Levu is the main island of the group, and Lautoka is the administrative centre of the Western Division of Fiji, situated roughly in the square bounded by 177° and 178° West, and 17° and 18° South. The cases surveyed come from the area around Lautoka, extending to the townships of Tavua and Nadi as shown on Figure 1.

FIG. 1.—North-west Viti Levu.



*Consultant physician, Lautoka Hospital
Accepted for publication January, 1975

Off the coast of north-west Viti Levu are two strings of volcanic islands, with numerous and treacherous fringing reefs abounding with fish, with a barrier reef some 30 miles on average from the main coast-line. The area is part of Bligh Water, a name commemorating the epic voyage made through here by Captain Bligh and his crew in an open long-boat after the famous mutiny in 1789. Incidentally a report has recently appeared suggesting that Bligh's crew were stricken with ciguatera near the north coast of Australia.²

From November, 1973, to October, 1974, records were kept on a designed proforma of cases presenting at the various out-patient departments and health centres run by the Fiji Government in the areas near Lautoka Hospital. The figures presented here are not comprehensive, as reporting tended to be sporadic. However, notifications made by the most reliable and consistent of the medical officers working in these areas form the basis of this report; they give an idea of the pattern of the disease while not showing the true extent of the problem.

Nothing short of a house-to-house survey would demonstrate the real incidence of the disease, as people are so used to fish poisoning that they very often do not seek help. Some of the cases presenting to the Lautoka Hospital out-patient department, and those few patients admitted, were seen personally, but otherwise this note is the work of the Fiji Government medical officers stationed in the area. Cases who had mainly gastro-intestinal symptoms were not included unless tingling, numbness, joint pains or muscle pains formed part of the presenting picture. Only six cases were excluded on these grounds.

TABLE 1.—Incidence of fish poisoning by fish name.

FIJI NAMES	ENGLISH NAME	SCIENTIFIC NAME	NO. OF CASES	PERCENT
Oqo)	Barracuda	<i>Sphyraena barracuda</i>	51	38.8
Silasila)				
Damu	Red Snapper	<i>Lutjanus Bohar</i>	23	17.6
Kawakawa	Grouper	<i>Epinephelus fuscoguttatus</i>	15	11.5
Kawago	Snapper	<i>Lethrinus ramak</i>	9	6.9
Dokanivudi	Sea-bream	<i>Lethrinus miniatus</i>	7	5.3
Saqa	Jack Crevally	<i>Caranx sp.</i>	4	3.1
Qio	Shark	? <i>Carcharhinidae</i> Family	3	2.3
Sabutu	?	<i>Lethrinus sp.</i>	3	2.3
Walu	Spanish mackerel	<i>Scomberomorus commersoni</i>	2	1.5
Unidentified			14	10.7
TOTAL			131	100%

Results

The survey comprises 131 cases. The area where the fish was caught could only be stated in 30 cases. No distinct pattern emerged, the fish having been taken over various coral outcrops all well within the barrier reef. It is an interesting reflection of social change and increasing urbanization that 101 cases reported the fish as having been bought at the local markets or from a trading store.

Table 1 shows the list of fish involved. The names are given as stated by the patients. The common English and the scientific names are given as usually accepted, but specific names may be inaccurate. Native names also vary in different parts of Fiji.

The monthly incidence is displayed in Figure 2. Clinical features were as follows:

SYMPTOMS	NUMBER	PERCENT
Abdominal pain	102	(77.9%)
Paresthesia	88	(67.2%)
Nausea	73	(55.7%)
Vomiting	56	(42.7%)
Myalgia and arthralgia	42	(32.1%)
Dysesthesia	28	(21.4%)
Sweating	19	(14.5%)
Giddiness	15	(11.5%)
Itch	6	(4.6%)
Taste disturbance	2	(1.5%)
SIGNS		
Bradycardia	12	(9.2%)
Hypotension	12	(9.2%)
Tachycardia	10	(7.6%)
Hypoflexia	9	(6.9%)
Dilated pupils	2	(1.5%)
Hyperreflexia	1	(0.8%)

Comments

Had this study been done a decade ago, it is unlikely that 10% of fish consumed would have been unknown by name, but such a percentage is understandable when it is realized that fewer people are now catching their own fish. Local stores and markets equipped with freezers are the major outlets for professional fishermen, and a considerable, though illegal, trade is conducted on the beachfronts. Many fewer people nowadays have time to go fishing, but the high proportion of "fish bought" in this series is still

surprising.

In Tahiti, 65% of poisonings result from eating fish of the Acanthuridae family (surgeonfish).³ Herbivorous fish of this type are not popular in Fiji, but they certainly are eaten; however, I have not heard of a case of ciguatera resulting from ingestion of anything other than a full carnivore in this area, and the list in Banner and Helfrich's paper does not include a herbivore. Comparing the comprehensive figures from Tahiti with the limited figures obtained in this study (Table 2), it appears that, even among carnivorous fish, the main culprits are different.

TABLE 2.—Comparison, Fiji and Tahiti

FAMILY	PERCENTAGE OF TOTAL CARNIVORES IMPLICATED	
	FIJI	TAHITI*
Sphyrenidae	38.9	2.4
Lutjanidae	17.6	15.4
Lethrinidae	14.5	18.2
Serranidae	11.5	33.9
Carangidae	3.1	13.7
Carcharhinidae	2.3	—
Scombrodidae	1.5	—

*Figures derived from Bagnis (3).

Traditionally the "damu", which is the red snapper, *Lutjanus bohar* (Forsk.), is the most suspect fish; particularly towards the end of the year many people refuse to eat it. Indeed, it is banned from sale in some markets. (This fish is also often called "batidamu"; in some areas "bati" and "damu" refer to different but related species of snapper). Nevertheless, this group ranks second in the list.

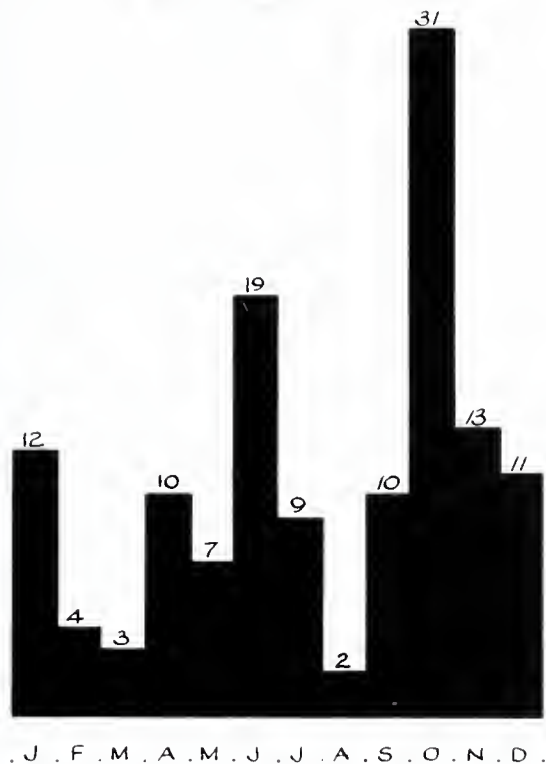
Fish of the Serranidae family are popular and moderately abundant, but do not form as high a proportion of the culprits as they do in Tahiti. The "saqa" which is of the Carangidae family is even more abundant, but apparently only seldom toxic.

During the past few years it has seemed that the barracuda were the most toxic fish in the area. Such an impression is borne out by this study in which the Sphyrenidae head the list. They are certainly abundant in these waters, but locally have not yet achieved the same notoriety as the "damu".

People in Fiji regard fish as toxic towards the end of the year and associate this with the an-

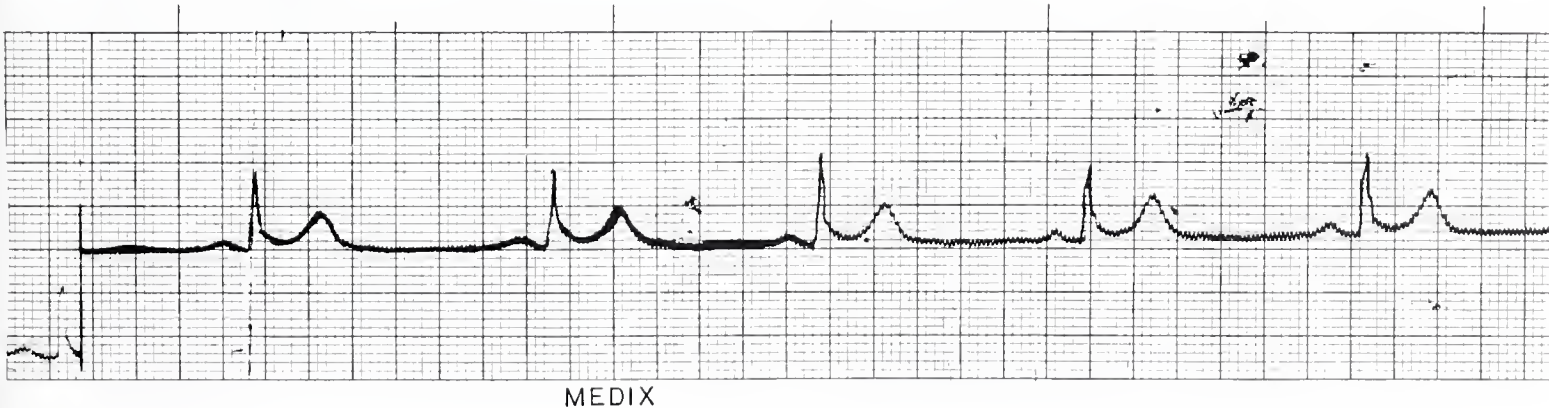
nual rising and spawning of the annelid worm, the "balolo". Ciguatera disease occurs throughout the year in other parts of the world,⁴ and Fiji is no exception. Figure 2 shows that there is a peak in October, but this is before the "balolo" rise. If there is an association it is certainly not one of cause and effect.

FIG. 2.—Monthly incidence of poisoning cases.



The precise definition of ciguatera disease has never been made. Scientifically it should describe the group of symptoms and signs resulting from the ingestion of fish whose flesh contains the "ciguatoxin" first isolated by Scheuer et al.⁵ This is, of course, an impractical definition in a clinical setting. Although I have excluded cases showing only a gastro-intestinal upset from this series, it is probable that ciguatera may manifest without symptoms involving other systems. Abdominal pain and/or gastro-intestinal upset associated with paresthesia usually taking the form of tingling of the lips and tongue should be sufficient to make a diagnosis of ciguatera poisoning. Myalgia and arthralgia are the next most common symptoms.

FIG. 3—Electrocardiograph tracing taken from patient with ciguatera from ingestion of barracuda. Rate: 48/minutes. PR interval: 0.18 seconds.



The table of symptoms presented does not include the term "weakness" although all patients without exception complained of this, sometimes to a profound degree, and not explicable purely on the basis of fluid and electrolyte loss from diarrhea. Itchiness has been described as so prominent a symptom that the disease is known as "la gratte" in New Caledonia. In our series only six cases had this complaint, but one of those progressed to a state of superficial exfoliation. Tonge et al⁶ state that sweating is extremely common, "so much so that it has been suggested that if a patient with gastro-intestinal upset is sweating profusely, one should inquire whether he has recently eaten reef fish." This symptom, however, was only reported in 14.5% of our cases. Even in those cases with severe weakness, marked paresthesia and diminished ankle jerks, weakness of the respiratory muscles was not a feature, although in one case with profound bradycardia and hypotension it was felt that respiratory failure was pending because intercostal movements were poor.

Bradycardia can be a startling sign. Figure 3 shows an electrocardiograph tracing obtained from a man who had eaten "oqo" and developed gastro-intestinal symptoms, bradycardia and the typical symptoms of tingling when exposed to a mild breeze and burning of the hands when immersed in cold water. The arrhythmia in this case was a sinus bradycardia.

Bagnis³ has observed that ciguatera resulting from ingestion of surgeonfishes results in a syndrome in which digestive and neurologic symptoms are prominent, whereas ingestion of carnivores produced a broader spectrum of symptoms. This series contains no case of "herbivoregenic" ciguatera and the symptoms are diverse. It may be that more than one toxin is involved. The flesh toxin of the surgeonfish has similar properties to ciguatoxin, but another water-soluble toxin was isolated from the stomach and liver of these fish.⁷ One often comes across the statement that, provided a fish is cleanly gutted, poisoning will not ensue. This is manifestly untrue of ciguatoxic fish, but it is pos-

sible that such an idea may have arisen by empirical observations with fish who were not ciguatera toxic but whose viscera may have contained the other toxin.

Treatment

Treatment remains symptomatic. Although ciguatera toxin was thought to be an anti-cholinesterase,⁸ later work has suggested that it acts by competing with calcium ions for receptor sites regulating sodium permeability across the cell membrane.⁹ Logically, therefore, flooding the extracellular compartment with sufficient excess of calcium ions could counteract the effect of ciguatera toxin. The use of 10 ml of 10% calcium gluconate has proved to be disappointing. Since in none of our cases was the disease life-threatening, the risk of using higher doses was not thought to be justified.

Bradycardia responds to atropine which may have to be repeated every 2 to 4 hours. Other symptoms are self-limiting and can be dealt with by supportive therapy.

High dose thiamine hydrochloride injections have been shown in our hands to be no more effective than "high dose" distilled water injections. The drugs most in use by our medical of-

ficers are promethazine hydrochloride and compound codeine tablets.

Summary

Ciguatera disease is prevalent in Fiji. The results of a survey conducted over one year in north-west Viti Levu part of the Fiji Islands is presented. Among the 131 cases, the commonest fish implicated was the barracuda. No herbivorous fish were involved. Gastro-intestinal symptoms and paresthesia were the predominant manifestations, sinus bradycardia being the most important of the autonomic nervous system signs of the disease. The disease is of a mild nature, and treatment is symptomatic and supportive. The author is inclined to support the idea that more than one poison is involved.

Acknowledgements

The author wishes to thank all the medical officers who reported their cases and, in particular, Drs. J. Foi and K. Minus. Mrs. B.K. Bird of the Hawaii Medical Library, Inc., in Fiji for two years, has been of immense help with the literature. Permission to publish granted by the Permanent Secretary for Health, Fiji, is gratefully acknowledged.

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“MAC” is Inacceptable!

The lowest available generic price of any drug, plus a limited mark-up, is generally the most the Federal government would pay under the proposed HEW rules for Maximum Allowable Cost (“MAC”) for Drugs, cited in the Federal Register, November 15, 1974.

Patients reimbursed under federally sponsored programs are surely entitled to the best medical care their physician is able to give them. This requires, of course, his freedom to prescribe exactly the drugs—and, where indicated, the brand of a drug—he believes they should be given. No ethical physician could assume responsibility for a patient’s care if this freedom is restricted.

Yet its restriction is precisely what HEW proposes—through the mechanism of a Pharmaceutical Reimbursement Board, composed of “five employees of the Department of the Office of the Assistant Secretary for Health”. They are empowered to decide, if they are challenged, whether there are substantial grounds for reviewing their own determination. In the event that they do decide to review it, they are also authorized to decide whether they are wrong or not.

If anything has been settled about the question of therapeutic equivalency, it is that it is still an unsettled question. There is no question, however, about the responsibility of a physician for his patient’s welfare, and the necessity for him to be able to act in accordance with his best professional judgment. To tell him he may not give exactly the medicine he believes is needed places an intolerable restriction on his exercise of this judgment. And the complexity of the nit-picking details of the law are calculated to drive pharmacists, institutional administrators, and physicians right out of their minds.

HEW must not be allowed to inflict such unreasonable requirements upon the health professions, and to demand from the medical profession a product we are sworn not to give: second-rate medical care!

HLA

High School Football Injuries

Frank Tabrah’s study of disabling injuries sustained by high school football players, published in the *HAWAII MEDICAL JOURNAL* in 1963¹, was unfortunately not known to the authors of the article on that subject² which appeared in our last issue, nor to the member of the editorial staff who processed that article for publication while we were out of town. It will bear, therefore, a brief review here.

Dr. Tabrah, then practicing in Hawi, in Kohala, on the Big Island, studied this problem in two high schools, a private and a public one, for both of which he was team physician. He found, in summary, that in one season, 92 disabling injuries occurred in 7,350 man hours of practice and 140 man hours of play. Of these, 69 occurred during actual play. The frequency of such injuries is nearly 14,000 times higher than the frequency of injuries of only very slightly higher severity in the nation’s most hazardous industry: underground coal mining.

It was Dr. Tabrah’s opinion that the almost hysterical disregard of risk which characterizes football play was a major factor in the production of these injuries.

Interestingly, Tabrah found no apparent relationship between the weights of players and either the frequency, or the severity, of injuries. It is also of interest that among the 92 injuries which he documented, there were no cases of injury to the spinal cord, and only one of a fractured vertebra.

Tabrah called attention to the fact that this extraordinarily hazardous sport, on which so much money is spent (and of course made!) is almost the only sport that virtually no-one engages in again, unless professionally, after high school and college. He suggested—ineffectually, it would seem, as might have been anticipated—that more emphasis be placed on other sports.

The just-published article by Okihiro, Taniguchi, and Goebert² makes it clear that the problem is still very much with us, and that it is an extremely serious one. Something needs to be done. But what?

HLA

REFERENCES

1. Tabrah FL: High School Football: Valuable Sport, or Sado-masochistic Excess? *HAWAII MED J* 23:106 (Nov-Dec) 1963.
2. Okihiro MM, Taniguchi R, Goebert HW: Football Injuries of the Cervical Spine and Cord, *HAWAII MED J* 34:171 (May) 1975.



H. TOM THORSON

Dr. William Dang, President-Elect, and Tom Thorson, Exec., attended the National Conference of State Legislatures, May 8-9, 1975, in Washington, D.C. Also attending from Hawaii were State Senators Dennis O'Connor and Anson Chong; State Representatives Herbert Segawa, George Clarke, Henry Peters, and Lisa Naito. The sole topic of the meeting was medical malpractice insurance. In preliminary discussion with Senator Inouye, it was clearly stated that the primary responsibility for developing solutions to the problem rests with the various states and that federal legislation is a last-resort idea. (HMA had already filed testimony relative to S.215 that had been submitted by Senator Inouye with Senator Kennedy). Senator Kennedy was the headlined luncheon speaker.

The meeting was a "What to" and "How to" session. Speakers of national note discussed various aspects of the problem and what could be done about it. Some felt that the crisis was absolute while others felt that we were only in the initial steps and that the real crisis crunch was yet to come. Several problem areas exist—

1. Professional controls—

- a. Sick doctor statute
- b. The incompetent or careless doctor (re-examination?)
- c. Relicensure(?)
- d. Full protection for Peer Review Committees!!!

2. Judicial principle review—

- a. Res ipsa Loquitur
- b. Implied warranty
- c. Informed consent

3. Procedural matters—

- a. Arbitration—pre-trial, compulsory, binding???
- b. Measure of damages—awards commission?
- c. Reversionary trusts instead of lump sum

awards to eliminate the "instant millionaire" heir.

d. Ad damnum statute eliminating the declaration of an amount prayed for in the suit.

e. Limitation of liability.

f. Burden of proof statute.

g. Notice of intent to sue.

4. **Administrative**—The insurance departments of the various states are trying to administer what is essentially an interstate activity with little or no uniformity in the statutes of the several jurisdictions. They would like more uniformity in the state codes.

a. Statute of limitations.

b. Mandatory professional liability law.

c. Counterclaim law

d. Evidence law.

e. Experience disclosure.

f. Statute of frauds.

What with the changing concept of malpractice insurance from a protective device for the doctor to insure his assets in the event of error, to that of a compensation mechanism for patients with less than satisfactory results, and with the increasing propensity of the public toward litigation, along with the social emphasis on consumer protection, it is obvious that there is no short road home. The 1975 Hawaii legislature has enacted a joint underwriting bill. This has been signed by the Governor and provides that in the event that a substantial number of professionals cannot buy coverage, the Insurance Department may invoke the bill requiring all casualty carriers to participate in a malpractice insurance pooling arrangement. This has some similarities to the "assigned risk" auto insurance statute.

Where are we? At this moment Argonaut is still accepting applications, subject to review by the HMA Professional Liability Committee. This may end on December 31, 1975, but this decision *has not* been finalized. Policies now being written will not be cancelled but will run for their full period. The situation could change and change quickly—much depends on the outcome of legal hassles on the mainland. Frankly, it appears that we have a red hot volcano under us.

What to do? First steps have been taken with the joint underwriting law. Next we have to move to develop operating procedures under this law so that if it has to be implemented, we will be ready to go. A committee is being put together under the direction of the Deputy Commissioner of Insurance to do just that. Next, we need to develop legislation that will create a favorable climate for the insurance carriers to ensure that they can operate at a reasonable profit. Groundwork has been laid for this and HMA is proceeding in a joint effort with the legislators to develop just such a legislative package well before the legislature convenes in 1976.

Alternatives—there are several of varying degrees of attraction. A true reciprocal has been suggested wherein the medical society assumes the basic function of a self insurance program with an excess coverage for catastrophic claims. This has a number of problems that cannot be covered here.

Another idea means the formation of a true mutual, doctor-owned insurance company. Hazardous because of our small size.

There are others that bear exploring and are being explored.

One thing we learned emphatically—There is no easy answer and there is no single approach. HMA now has a good communication channel with the legislature and we are talking the same language. This is a solid opportunity for good constructive legislative action to clarify and correct some of the problems that may be taken care of through legislation. Others rest with the profession itself in the area of peer review and discipline accompanied by a continuing education program that is effective.

Now a message from HAMPAC—To date there are only 175 out of 990 physician members of HMA who have joined or renewed their 1975 membership in the Hawaii Medical Political Action Committee (HAMPAC) and American Medical Political Action Committee (AMPAC).

HAMPAC and AMPAC are voluntary, non-profit, unincorporated groups whose bi-partisan memberships consist of physicians, their spouses, and members of allied medical professions. HAMPAC and AMPAC spend membership dollars wisely, using proven methods of evaluation in deciding whether or not to contribute to a candidate. Since membership dollars are primarily contributed by physicians to HAMPAC and AMPAC, the decision on the disposition of these political funds is made by physicians. Before political funds are allocated the following campaign aspects are evaluated: 1) the degree of active and financial support on the part of local physicians for the candidate; 2) the disposition of the candidate toward giving medicine's views a fair hearing; 3) the candidate's chances for success; 4) the degree of professionalism in the campaign; 5) the need of the candidate for additional political campaign support funds.

A \$20.00 contribution to HAMPAC will enable you to either join or renew your 1975 membership in both HAMPAC and AMPAC. Make your personal check out to HAMPAC and address it to HAMPAC, 510 S. Beretania Street, Honolulu, Hawaii 96813.

AMA Meeting in June in Atlantic City. The AMA Board of Trustees has recommended a major increase in AMA dues. This will come before the House of Delegates at the annual meet-

ing and no doubt will set off another marathon discussion. HMA has submitted a resolution to AMA relative to some kind of professional recognition being given to the Medical Officers of the Trust Territories and Samoa. At the moment they are neither fish, flesh, nor fowl although they represent the major component of service personnel in the areas.

Continuing Education For Lawyers—Several states, led by Minnesota, are instituting mandatory continuing education for attorneys.

Injunction Granted by the federal court halting enforcement of new utilization review regs for Medicare and Medicaid hospital administrations that were to become effective July 1. More later.

Job Opportunities—The Indian Health Service is seeking physicians to staff hospitals in the Dakotas, Minnesota, and Nebraska—One of the enticements is **NO MALPRACTICE INSURANCE IS REQUIRED**. If you are interested contact—

Edward White, Physician Recruiter
Aberdeen Area Indian Health Service
Federal Building
Aberdeen, South Dakota 57401 or call collect 605-225-0250, Ext 451 (remember the five hours time differential.)



Thomas C. Chen, M.D.

305 Wailuku Drive
Hilo, Hawaii 96720

INTERNAL MEDICINE



Jiro Nakano, M.D.

Hilo Medical Group
Hilo, Hawaii 96720

INTERNAL MEDICINE and
CARDIOLOGY



Pharmacy Committee

The HMA Pharmacy Committee wishes to issue the following memo:

All physicians who prescribe or dispense controlled or noncontrolled drugs should conform to existing laws governing the prescribing and dispensing of such drugs. We also solicit your aid in educating patients regarding certain rights and in complying with a request from the Investigations and Narcotic Control Section of the State Department of Health to more closely supervise prescription pads. The following areas merit your attention.

1. REFILLS

- We encourage physicians to specify a time limitation, one-year at most, on all refills of prescriptions. We suggest that PRN refills without specific time limitation be automatically non-refillable after six (6) months.
- Only physicians may legally authorize refills.** In every situation where a pharmacist calls to verify refills, the physician alone should make the decision. **PLEASE ALERT YOUR OFFICE STAFF TO CONSULT WITH YOU IN EACH CASE WHEN THEY RECEIVE SUCH REQUESTS.**

2. CONTROLLED SUBSTANCES

- The Investigations and Narcotics Control Section of the State Department of Health reports that each month approximately 20 requests for controlled substances written on *stolen* prescription blanks are presented to Pharmacies. This situation is abetted by careless supervision of your prescription blanks. The State's solution to this problem is the **TRIPPLICATE PRESCRIPTION PLAN** that will require physicians to use serially numbered, State issued (cost to physician) prescription blanks for all controlled substances. They feel this will discourage theft of prescription blanks from physician offices. However, they have agreed that tighter safeguarding of prescription pads by physicians may forestall such State action. **MAKE EVERY EFFORT TO PREVENT THEFT OF YOUR PRESCRIPTION BLANKS.**
- They also remind us that the drug abuser may try to obtain a prescription for controlled substances under a variety of false pretenses. **WRITING A PRESCRIPTION FOR CONTROLLED SUBSTANCES WITHOUT SEEING THE PATIENT IS TO BE CONDEMNED.**
- Another reminder is to affix your DEA (BNDD) number on all prescriptions for controlled substances.

3. INFORMING YOUR PATIENT

- In view of much criticism of late regarding the "bondage" of our patients, the Pharmacy Committee recommends that the dispensing physician display the following sign near his drug room.

"YOUR MEDICATION MAY BE PURCHASED HERE OR AT THE PHARMACY OF YOUR CHOICE ON PRESCRIPTION"

Signs will be available on request at the HMA office.

4. DISPENSING DRUGS

- Physicians who dispense must conform to existing laws governing the dispensing of *all* prescription drugs. These laws pertain to **LABELING** (Hawaii Food, Drug and Cosmetic Act, Section 328-16) and to **PACKAGING** (Poison Prevention Packaging Act of 1970). Excerpts of these regulations are listed below. An example of proper labeling and a proper container are also shown.

Labeling Law:

16,536 Hawaii 489 6-26-72

[¶16,526A] Drugs Limited to Dispensing on Prescription

§328-16... (D) its label bears the name and place of business of the seller, the serial number and date of the prescription, and the name of the practitioner. If any prescription for such drug does not indicate the times it may be refilled, if any, such prescription may not be refilled unless the pharmacist is subsequently authorized to do so by the practitioner. The act of dispensing a drug contrary to this subsection shall be deemed to be an act which results in a drug being misbranded while held for sale.

REQUIRED:

- Name of M.D.
- Address of M.D.
- Date of Rx.
- Instructions.
- CAUTION on all scheduled drugs.

OPTIONAL: (RECOMMENDED)

- Identify drug.
- Specific time of doses.
- Quantity dispensed.
- Expiration date.
- Specify refill.

J. D. SMITH, M.D.

Room 999 2220 S. KING ST. HONOLULU, HAWAII 96814

Phone 947-2651

43- 40549 Dr. Smith

John Doe 3/11/75

Take one tablet at 9AM and 9 PM daily.

TETRACYCLINE 500mg (Squibb)
(24)

Discard After: June '77 Refill No Times

CAUTION: FEDERAL LAW PROHIBITS THE TRANSFER OF THIS DRUG TO ANY PERSON OTHER THAN THE PATIENT FOR WHOM IT WAS PRESCRIBED

Packaging Law:

8606 Hazardous Substances 567 12-10-73

[¶9623] Poison prevention packaging standards

§1700.15 To protect children from serious personal injury or serious illness resulting from handling, using, or ingesting household substances, the Commission has determined that packaging designed and constructed to meet the following standards shall be regarded as "*special packaging*" within the meaning of section 2(4) of the act. Specific application of these standards to substances requiring special packaging is in accordance with §1700.14.

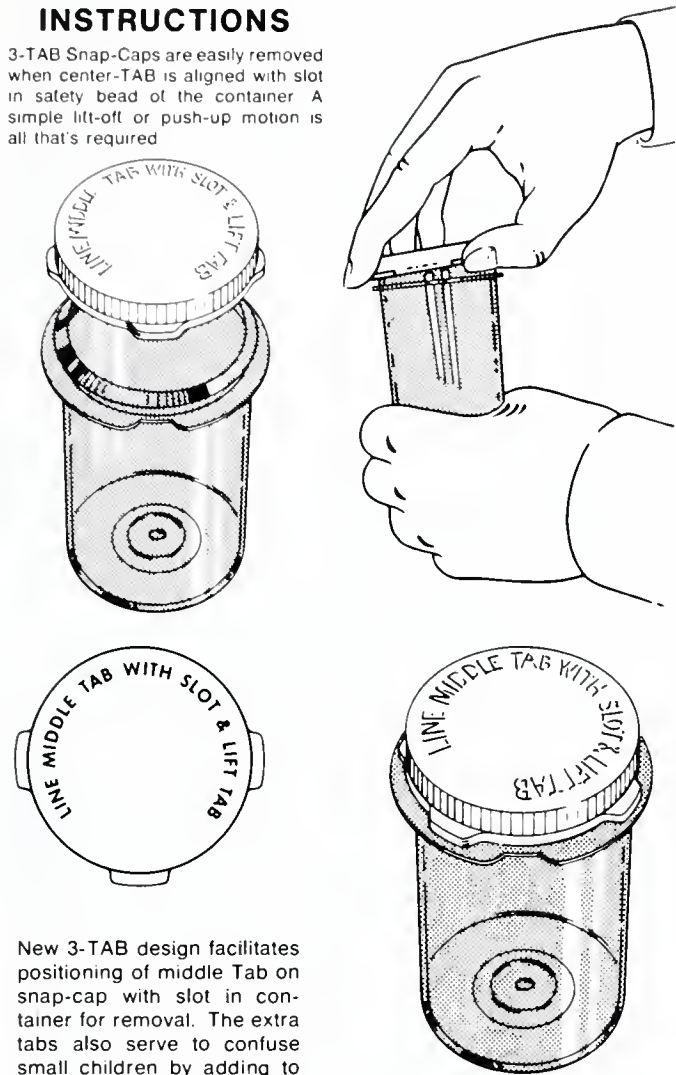
(4) "*Special packaging*" means packaging that is designed or constructed to be significantly difficult for children under 5 years of age to open or obtain a toxic or harmful amount of the substance contained therein within a reasonable time and not difficult for normal adults to use properly, but does not mean

packaging which all such children cannot open or obtain a toxic or harmful amount within a reasonable time.

Snap-Cap Closures

INSTRUCTIONS

3-TAB Snap-Caps are easily removed when center-TAB is aligned with slot in safety bead of the container. A simple lift-off or push-up motion is all that's required



New 3-TAB design facilitates positioning of middle Tab on snap-cap with slot in container for removal. The extra tabs also serve to confuse small children by adding to difficulty in opening container until correct tab is in proper alignment.

Closure may be reapplied to the vial with the same easy application as a conventional snap-cap. CAUTION: When closing, be sure middle tab is not aligned with slot in safety bead of container.

Waiver:

Must be signed by patient and kept in file in patient's records.

I request safety RX containers not be used _____

Report of Delegate to the United States Pharmacopoeial Quinquennial Meeting, March, 1975.

The meeting was well attended. Major items of business accomplished were the revision of the constitution and by-laws to allow for the combination of the United States Pharmacopoeia and the National Formulary. From now this country will have only one official compendium. The new officers and the new committee on revisions were elected.

Several resolutions were passed which serve as mandates for the board of trustees. In general these resolutions would strengthen the USP and make it a more functional and useful book for clinicians. Three resolutions had to do with strengthening the USP-NF programs of standard setting to insure *uniform bioavailability*. This, to me was one of the more important actions taken, and the USP should move actively into this area during the next five years. One resolution that passed resolved that standards setting by USP-NF criteria should be extended to all drugs of proven efficacy as therapeutic agents. As it is now, only about 40 per cent of drugs on the market have official standards. Of course, many of the remaining 60 per cent have not been proved to be efficacious. This extension of USP-NF activity must be a long range project and may not be financially feasible at present. The USP-NF has good financial strength, but problems are pending. Some income has come from government contracts and there was debate as to whether direct government grants or subsidies should be sought. A resolution instructing the trustees to explore the feasibility of government financing barely passed. There was a strong feeling, shared by me, that the USP-NF should remain the solid independent organization that it is today. The resolution was finally weakened by amendment so that the trustees are instructed to "explore the feasibility" rather than to actively seek government aid. Several other minor resolutions were passed, and many other resolutions that would have changed the character and scope of the USP failed. The members of the convention visited the new USP-NF headquarters in Bethesda. It is a modern, well-equipped, functional building near the FDA and the NIH. There was much in the way of minor or housekeeping business that I have not reported in this letter. Further specific information can be obtained by calling me.

DANIEL D. PALMER, M.D.

Continuing Medical Education

ELIZABETH K. ANDERSON, M.D.

News in CME:

Kaiser Hospital will undergo preaccreditation survey of its CME programs on July 9, with Ivar Larson, M.D. as chairman of the HMA team. The HMA Seminar/Workshop held on May 12 and 13 for "Developing Accredited CME Programs Using Patient Care Audit Methods" was filled to capacity and enthusiastically received. Every hospital in the State was represented. Evaluation questionnaires distributed after the program indi-

cated it was helpful to the great majority of the nearly 100 attendees. But the majority also indicated that very little formal connection exists at present between CME programs and patient care audit of their institutions. Hopefully, this workshop showed various means for making this relationship much closer in all hospitals, as this should ideally be the case.

June 30, 1975 is the deadline for the AMA to receive applications for the 1974 Physician's Recognition Award. **HAVE YOU RECEIVED YOURS? IS IT CURRENT?** The HMA has strongly urged all physicians to obtain this as documented evidence of their CME activities.

CALENDAR OF ACCREDITED EVENTS—CATEGORY I

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS:

Kauikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital

1. Tuesdays—CME Program, 1:00-2:00 p.m.
2. Grand Rounds, 2nd and 4th Mondays—5:00-6:00 p.m.
3. Visiting Professor Programs (see Special Events)

Kuakini Hospital

Ongoing

1. Hematology Conference, Monday, 8:30-9:30 a.m.
2. Gastroenterology, Tuesday, 8:30-9:30 a.m.
3. Oncology, Thursday, 8:00-9:00 a.m.
4. Endocrine, 2nd Tuesday each month, 1:00-2:00 p.m.
5. Medical Statistics, 3rd Tuesday each month, 1:00-2:00 p.m.

August 9-20 Eighteenth Annual Postgraduate Refresher Course presented by USC and U of H School of Medicine in Association with Tripler (Fee charged)
Honolulu (Sheraton-Waikiki Hotel)
August 9-15; Maui (Maui Surf Hotel)
August 18, 19 Kona (Kona Surf Hotel)
August 18, 19 Program is on HMA Bulletin Board
Contact: Phil Manning, M.D.
USC, 2025 Zonal Avenue
Los Angeles, California 90033

August Kapiolani Hospital Visiting Professor Programs. M. Stenchever, M.D.

September 21 "Hypertension" sponsored by Hawaii Heart Association and Hawaii Medical Association; at the Princess Kaiulani Hotel, Honolulu. For further information call Mrs. Austin, Hawaii Heart Association, phone 538-7021

September 28 Conference on Alcoholism, "New Diagnostic and Treatment Methods," sponsored by Hawaii Psychiatric Society, APA, HMA, Department of Health, University of Hawaii. Details to follow.
Contact: Bernice Coleman, M.D.
Phone 737-7811

October 3-8 Sixth Asian Pacific Society of Cardiology Sheraton Waikiki, Honolulu
Contact: Morton Berk, M.D.
550 S. Beretania, Honolulu 96813

November 29- American Medical Association
December 5 Clinical Session
Sheraton Waikiki, Honolulu
Contact: Frank A. Gray, AMA Convention Services Department
535 N. Dearborn St.
Chicago, Illinois 60610

December 5-11 Cleveland Academy of Science
Kona Surf/Sheraton Maui
Contact: Donald Mortimer
10525 Carnegie Avenue
Cleveland, Ohio 44106

OUT OF STATE:

AMA Regional CME Programs—

8 Courses offering Category I credit

- 1) Dermatology for non-Dermatologists
- 2) Infectious Diseases and Antibiotics
- 3) Fluid and Electrolyte Balance
- 4) Venereal Disease
- 5) Pulmonary Function and Blood Gases
- 6) Basic and Advanced Support CPR
- 7) Basic ECG
- 8) Human Sexuality
 - a) Minneapolis, Minnesota (July 26-27)
 - b) Williamsburg, Virginia (September 27-28)

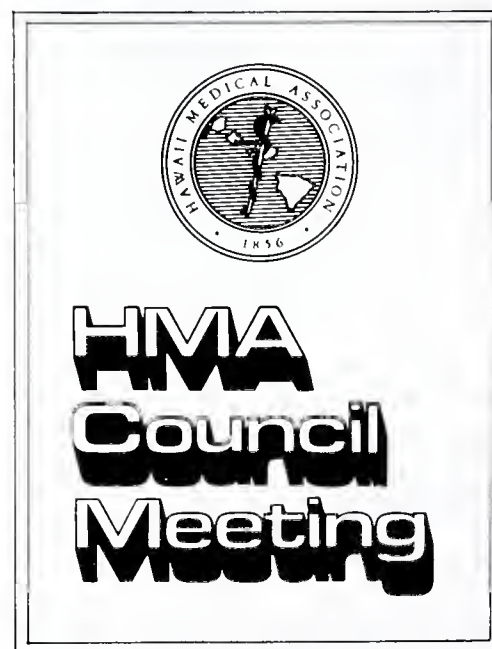
For further information, write:

Department of Scientific Assembly
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610

American College of Physicians Courses:

June 23-27 *Advances in Internal Medicine: Horizons and Perspectives*
University of Alberta, Banff, Canada
For further information, contact:
Registrar of Postgraduate Courses
American College of Physicians
4200 Pine Street
Philadelphia, PA 19104

Further listings: For further detailed listings of numerous Category I accredited CME courses taking place in California and in other states, see the CME Bulletin Board at the HMA Office or refer to the JAMA, special issue on continuing medical education. Listings of weekly lectures and rounds of *not yet accredited local institutions* (Category 2 credits) will also be posted as they are received.



Friday, March 14, 1975, 5:30 p.m.
Mabel Smyth Lanai

CALL TO ORDER

The meeting was called to order by President Winfred Y. Lee. Present were Drs. William W.L. Dang, R. Varian Sloan, Grover H. Batten, Herbert Y.H. Chinn, J.I.F. Reppun, Arnold Siemsen, John Edwards, Carl Lum, Rowlin Lichter, Sakae Uehara, Verne Adams, Peter Kim, and Albert Chun-Hoon plus Drs. Douglas B. Bell II, Alan Pavel, and Vincent Aoki, and Attorney V. Thomas Rice.

MINUTES:

The minutes of the February 14, 1975, meeting were approved as circulated.

REPORT OF THE TREASURER

The financial reports for January and February 1975 were filed subject to audit.

COMMITTEES AND COMMISSIONS:

A. *Pharmacy Committee*: The Pharmacy Committee presented a proposed educational bulletin regarding dispensing of drugs and labelling requirements. The bulletin will appear in the JOURNAL.

ACTION:

It was voted to approve the publication of the bulletin with a few minor amendments suggested by the Council.

B. *Professional Liability Committee*: The functions of the Professional Liability Committee were reviewed in detail including the manner in which the committee processes matters referred to it. This committee is appointed by the President of the HMA and there was some discussion as to whether or not it should be an elected committee.

ACTION:

It was voted to reaffirm the functions of the Professional Liability Committee as previously presented to the HMA Council on May 11, 1971.

C. *Peer Review Committee*: The purpose of the Peer Review of the HMA was also discussed. Mr. Rice noted that the bylaws of each county should be reviewed to be certain that procedures for due process in any disciplinary review are present. It was also recommended that the State Peer Review Committee functions be expanded to include the right to hear cases referred to it whenever decisions from a subcommittee are appealed.

ACTION:

It was voted to expand the function of the Peer Review Committee as suggested above and to recommend that the county medical societies submit their bylaws for review.

Legislation relating to a pooling bill to be activated by the insurance commissioner in the event all malpractice insurance is removed from the market was discussed at length by Mr. Thorson. The Department of Regulatory Agencies has invited the Association to participate on a committee which will review the entire malpractice insurance situation in the State including legislative proposals for introduction during the 1976 session of the Legislature.

D. *Internal Affairs*: The HMA Annual Meeting will be held October 24-26. The Convention Committee will also consider plans for activities during the AMA Clinical Session in Honolulu beginning November 29, 1975.

E. *Public Affairs*: The Hawaii Association of Professions has been contacted and asked to invite the pharmacists to join the Association. Dr. Lichter reported that the public forums cosponsored by HMA with the Hawaii Newspaper Agency continue to draw large crowds.

F. *Legislation*: Copies of testimony presented to the Legislature was distributed for the Council's perusal.

G. *EMS*: Dr. Dang reported that approval was given for the continuing standards of performance for the MICTs. He also announced that the universal emergency telephone number, 911, would become effective on March 20 for the island of Oahu.

H. *PL 93-641*: The Governor's Ad Hoc Committee on Area Designation for PL 93-641 continues to meet and requests that the various agencies represented relay their feelings regarding the area designation for Hawaii, and whether there should be one Health Service Area for the state or more than one area.

ACTION:

It was voted to recommend that one Health Service Area be designated for the State of Hawaii.

I. *Continuing Medical Education Activities*: Accreditation of hospitals is underway and Kaulaolani Children's Hospital has received accreditation and Kapiolani Hospital will also probably be accredited soon. These hospitals will be able to offer Category I credits for the Physician's Recognition Award. A Calendar of Continuing Medical Education now appears in each issue of the HAWAII MEDICAL JOURNAL. RMP Hawaii has allocated funds to HMA to sponsor a seminar for hospital teams throughout the state. The seminar will help hospitals develop accredited programs coordinating continuing medical education with patient audit activities.

J. *Cancer Commission*: Several meetings of the Commission have been held. Dr. Lee met with the Commission and asked them to outline the goals and objectives for the Cancer Commission for the coming year. At a subsequent meeting various legislative proposals were discussed. It is not likely that the Cancer Society will be able to provide a grant to the Hawaii Tumor Registry in 1975 and other sources of funding are being explored. Travel to the neighbor islands to assist the Act 97 hospital registries will not be possible without additional travel funds. Contract negotiations with the Cancer Center are continuing.

K. *Site Committee*: The Site Committee is presently considering a proposal to lease temporary office space (12,000 sq. ft.) while pursuing a more permanent location for the administrative offices. Further details will be available as they are received.

L. *PSRO*: The February progress report was circulated. Nomination materials have been mailed to all PSRO members for election of the PSRO Board.

OLD BUSINESS

A. A letter to Senator Daniel Inouye regarding no-fault malpractice insurance was circulated.

B. Appointees to various community committees and agencies were announced as follows:

- 1) Dr. William Dang and Dr. Herbert Chinn—Governor's Ad Hoc Committee on Area Designation for PL 93-641
- 2) Dr. Elisabeth K. Anderson/Dr. Grover Batten and Jon Won/Tom Thorson—Health and Community Services Council
- 3) Jon Won/Dr. William Dang—Waianae Comprehensive Health Center
- 4) Dr. J. I. F. Reppun—Department of Health Patient Education Program
- 5) Dr. Thomas Lau—Blood Cell Advisory Committee, St. Francis
- 6) Drs. Ann Catts and Fred I. Gilbert—Department of Health Laboratory Advisory Committee
- 7) Nominees for the Board of Medical Examiners: Drs. Ann Catts, George Goto, Albert Chun-Hoon, John Lowrey, William Dang, Winfred Lee from Honolulu and Drs. George Bracher, Richard Lundborg and James Matayoshi from Hawaii County

NEW BUSINESS

Publication of HMA Roster for 1975: The Association has received a proposal for publication of a new roster from Elson-Alexandre Company of Los Angeles. The terms of the proposal were circulated. The decision on the number of copies and number of editorial pages can be delayed until May.

ACTION:

It was voted to proceed with the proposal as outlined.

ACTION:

It was voted to separate the Bylaws from the Roster.

ADJOURNMENT

The meeting adjourned at 10:30 p.m.

R. VARIAN SLOAN, M.D.,
Secretary

Friday, April 18, 1975, 5:30 p.m.
Mabel Smyth Lanai

CALL TO ORDER

The meeting was called to order by President Winfred Y. Lee. Present were Drs. William W. L. Dang, R. Varian Sloan, Grover H. Batten, George H. Mills, Herbert Y. H. Chinn, George Goto, J. I. F. Reppun, Carl H. Lum, Ann B. Catts, Rowlin L. Lichter, John Kim, Sakae Uehara, Verne Adams, Albert Chun-Hoon, Marion Hanlon and Verne Waite. Also present were Drs. Douglas B. Bell II, Calvin C. J. Sia, William Iaconetti, and Elisabeth Anderson; and Mrs. Jackie Jones, Auxiliary President.

APPROVAL OF MINUTES

The minutes of the March 14, 1975 meeting were approved as circulated.

REPORT OF THE TREASURER

The financial statement for March 1975 was approved subject to audit.

REPORTS OF THE COMMITTEES AND COMMISSIONS

A. Site Committee: Representatives from Chaney, Inc. presented a proposal for leased office space to consolidate the operations of HMA/HCMS at one location. This proposal was presented as an interim plan until a suitable long-term or permanent site could be obtained. The proposal was reviewed in detail.

Dr. Chun-Hoon also reviewed another proposal which might provide a more permanent site for HMA/HCMS. The Site Committee will continue to investigate this possibility.

ACTION:

A motion to accept the Chaney proposal failed to pass.

B. Medical Education and Peer Review: A seminar on Developing Accredited Continuing Medical Education Programs in Hospitals will be presented on May 12 and 13 at the Mabel Smyth Building. RMPH is assisting the HMA and the California Medical Association in presenting the workshop. HMA was also notified that it may be possible to reactivate HMA's grant request for RMP funding of the Quality Assurance Program Development.

C. Public Health: Dr. Sia reported that the legislature approved a statewide school health program which will be implemented over a four-year period. Other appropriations were approved by the Legislature as follows: the Substance Abuse Agency was placed under the Department of Health, a new Commission for the Elderly was approved and a Developmental Disabilities Council will be established in the office of the Governor.

D. Health Services: The Health Manpower Committee is presently reviewing a health manpower survey proposed by the School of Public Health. The Council asked that the committee report back on the assessment of need for physician's assistants in this State.

E. Professional Liability: Dr. Chun-Hoon reported that a committee to study malpractice insurance problems is being formed by the insurance commissioner. Drs. Chun-Hoon and Pavel and Mr. Thorson will represent the HMA on the committee. Dr. Lee asked that the neighbor island counties appoint a representative to a special ad hoc committee on malpractice insurance. This committee will review various legislative proposals as well as develop recommendations for Council's consideration in meeting malpractice insurance problems.

F. Legislation: A summary of state legislation which passed the legislature was reviewed. A summary will appear in the HAWAII MEDICAL JOURNAL Newsletter.

G. EMS: A letter from Dr. Gebauer requests the HMA to return certain contract funds to the City and County of Honolulu to complete the radio system and upgrade the Medicom System in Kahuku, Wahiawa and the airport area.

ACTION:

It was voted to return the amount requested to the City and County of Honolulu.

H. PL 93-641: Dr. Dang reported that the ad hoc committee on PL 93-641 voted to recommend to the Governor that there be one health service agency for the State.

I. Cancer Commission: A signed contract between the RCUH, Cancer Center and HMA to continue the demographic contract with NCI was signed on April 1, 1975. There are no travel funds included in the contract as it was originally intended to fund travel expenses through a grant from the Cancer Society. This is not possible and Dr. Batten requested Council approval to utilize HMA funds for this purpose.

ACTION:

It was voted to approve the appropriation up to \$5,000 for travel for Hawaii Tumor Registry business.

J. Auxiliary: Mrs. Jones presented a written report on Auxiliary activities for the year. She was asked to present the AMA-ERF check to the medical school at the University of Hawaii at the graduation ceremonies.

K. PSRO: Dr. Lee announced that the deadline for nominations to the PSRO Board was extended to April 30. Ballots will be mailed at the end of May and it is expected that the installation of the Board will occur on June 24.

OLD BUSINESS

A. Letter from Senator Inouye: Senator Inouye invited written testimony on S 215 and other malpractice bills before Senator Kennedy's subcommittee on Health, Committee on Labor and Public Welfare.

ACTION:

It was voted to present testimony prepared by the Executive Committee.

B. Letter to Governor Ariyoshi: A copy of the letter written to Governor Ariyoshi on services to Medicaid patients was circulated. It was noted that a similar letter was written by the Physician's Action Group.

NEW BUSINESS

A. National Conference of State Legislatures: A legislative training program on medical malpractice will be held in Washington, D.C. on May 8 and 9.

ACTION:

It was voted to send two representatives to the Conference.

B. Conference on Medical-Legal Problems: Dr. Alan Pavel has been asked to attend a symposium on medico-legal problems given by the American Academy of Orthopaedic Surgeons in Chicago.

C. AMA Resolution: A resolution relating to compulsory enrollment in health insurance was submitted for Council's consideration.

ACTION:

It was voted to refer the resolution to the Delegate and Alternate Delegate for comments at the next Council meeting.

D. AMA Clinical Session: Council requested that the Convention Committee consider any special arrangements for the AMA Clinical Session and report their recommendations at a future Council meeting.

ADJOURNMENT

The meeting adjourned at 9:40 p.m.

R. VARIAN SLOAN, M.D.
Secretary

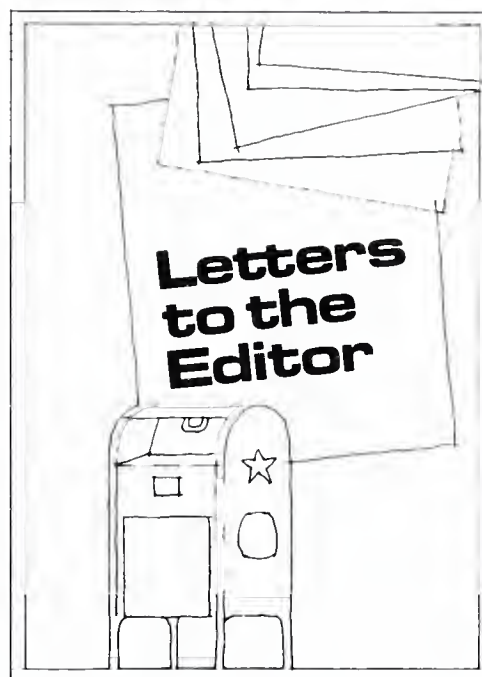
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It is estimated that within the next twenty years, at least 50% of the physicians in the United States regularly seeing patients will be in the form of medical groups. This book provides the physician with a frame of reference from which he can operate to form the group of his choice.

A review of the various types of groups and how they are run, as well as the good and bad points of group practice are carefully analyzed.

JAMES H. STEWART, M.D.



To The Editor:

In a recent article, "Rehabilitation of the Stroke Patient" by R. Frederick Shepard, M.D.; *Straub Clinic Proceedings* 40:85-6, (July-Sept.) 1974, it was implied that the rehabilitation of the stroke patient should be confined to the rehabilitation center where a "highly professional team" is available and that currently used protocols are too inflexible and fail to meet the individual needs of the patient.

These remarks deserve comment as they seem to run counter to the current philosophy of stroke rehabilitation. Of the approximately 500,000 persons in the United States who suffer a stroke each year, the great majority receive their care in the general hospital setting.¹ Most never set foot into a rehabilitation center. To adequately care for this large group of patients, general hospital personnel need stroke rehabilitation guidelines.

The protocol approach to treatment is to be commended in that it gives such guidance and allows the hospital staff to take an active and positive role in the stroke patient's rehabilitation. The protocol technique effectively deals with the problems of most—but not all—stroke patients. In the more complicated cases it should be the role of the attending physician and rehabilitation specialist to provide additional staff guidance.

If initial rehabilitation is neglected, the stroke patient is a prime candidate to develop such complications as contractures, pressure ulcers, phlebitis, and disuse muscle atrophy. It is generally agreed that rehabilitation should begin as soon as the patient enters the hospital with the initial goals being to preserve life and to prevent complications. As soon as there is medical stability and the patient's condition permits, he should be out of bed and involved in an active restoration program.^{2, 3, 4, 5, 6}

Following the above program, many patients can be functionally rehabilitated during their stay in the general hospital. The rehabilitation center can then be utilized more

Book Reviews



Building a Group Practice

By Fred W. Wasserman, M.P.H. and Michael C. Miller, M.P.H., 178 pp., \$7.95, Charles C. Thomas, 1973.

I have had the opportunity to review this book at length and I find it a most complete outline that any group of physicians may use in forming a group style practice.

efficiently in caring for those patients requiring a more prolonged and intensive rehabilitation program.

JOHN SCHUCHMANN, M.D., JONATHAN CHARNEY, M.D.
and JORDAN S. POPPER, M.D.

REFERENCES:

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2. Levenson, C: Rehabilitation of the stroke hemiplegia patient; in Krusen, FH, Kottke, FJ, Ellwood, PM: *Handbook of Physical Medicine and Rehabilitation*; Second edition; W.B. Saunders Co.; Philadelphia, 1971, pp. 521-553.
3. Alpers, BJ, Mancall, EL: *Clinical neurology*; Sixth edition; FA Davis Co.; Philadelphia, 1971, p. 218.
4. Rehabilitation Study Group: II. Stroke rehabilitation. *Stroke* 3: 375-407, 1972.
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Society of Nuclear Medicine

Richard Wasnich, M.D., President, Hawaii Chapter of the Society of Nuclear Medicine, will be the reporter for his society of the HAWAII MEDICAL JOURNAL.


Hawaii Thoracic Society

Dr. Philip Foti is now President of the Hawaii Thoracic Society. Gary Houghtby, Executive Secretary, will act as the representative of the Hawaii Thoracic Society to the HAWAII MEDICAL JOURNAL.

Hawaii Psychiatric Society

Dr. Marvit, immediate past president, announced the new Officers for the year beginning May 1975. Elected were: President—Noel Howard, M.D., LCDR, USN, President-Elect—Len Jacobs, M.D., Secretary—Bernice Coleman, M.D., Treasurer—Winifred Simmons, M.D. and Alternate Delegate—George Bolian, M.D.

DENNIS B. LIND M.D.



Hawaii Academy of Family Physicians' Newsletter

J. I. FREDERICK REPPUN, M.D.

News of Members—Bill WALSH has an announcement in the newspapers that he is resuming practice in the Alexander Young Bldg.

Mark Allen WENTWORTH is a new member of the Hon Cty Med Soc and, of course, of the Hawaii Medical Ass'n and the A.M.A.

Applications for Preceptorships—Charles Morin, 156 Plain St, Rehoboth, Mass 02769 has written to ask if there might be an opening in Hawaii with a Family Physician from July 7 to Aug 1; he has finished his 3rd year at Brown University School of Medicine. We have another request from the U of Iowa School of Medicine for one of their senior medical students for a 4-week period in August-September. Frank TABRAH assures us that there are more than enough "slots" here in Hawaii to satisfy the applicants from our own UHSM, so that if any of you are ready and willing to kokua the Mainlanders, please call our ExecSec.

New Members—Norina M. D'IORIO MD who is with Kaiser Permanente is a new Associate Member. Welcome! She has a spouse with a name of his own: Lloyd R. Woelfle.

Calendar—SAVE the Saturday night, 28 June, open for the next dinner meeting of HAFFP. It will be at REPPUN'S in Kahaluu, coming around full circle after several years, and our guest speakers will be Gerald FAULKNER MD on "The Latest about Eyes for the GP", and Ah Quon McElrath of the ILWU who would like nothing better than to have a sparring match with us Family Physicians in the jousting area of "Medico-socio-economics".

Massachusetts—Anyone care to move away from beautiful Hawaii? The University of Massachusetts School of Medicine is seeking a faculty for their new Department of Family Practice. If they can raid Hawaii, perhaps we can raid Massachusetts for talent!

Restructuring of membership and dues is in the works at the national level. The idea is to delineate a step by step rise from Student to full Active and then a decline to Inactive. The Hawaii Chapter Council will be asked to consider the following:

CATEGORY	NATIONAL DUES	STATE DUES
1a. Student	\$ 5.00	5.00
1b. Resident	15.00	15.00
2a. Assoc. in training	15.00	15.00
2b. Assoc. in practice	15.00	20.00
3. Active	75.00	20.00
4a. Sustaining	75.00	20.00
4b. Retired (Inactive)	15.00	15.00
4c. Honorary (Life)	10.00	10.00

If the House of Delegates in October does recommend anything like the above, it will not take effect until the House meets in 1976 or later.

Maybe the patient's self-diagnosis is right. He could have hay fever. But that bright red nasal mucosa, along with the thick discharge and excoriation around the nares, strongly suggests that the main problem is a cold. Hay fever or another form of allergic rhinitis may or may not be an underlying factor.

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such as alcohol, hypnotics, sedatives, tranquilizers, etc.

ADVERSE REACTIONS: Adverse reactions to Dimetapp Extentabs may include hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia; drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis, CNS-depressant and (less often) stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation, and epigastric distress.

HOW SUPPLIED: Light blue Extentabs in bottles of 100 and 500.

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Indications: Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

Ⓜ Phenaphen with Codeine is now classified in Schedule III, Controlled Substances Act of 1970. Available on written or oral prescription and may be refilled 5 times within 6 months, unless restricted by state law.

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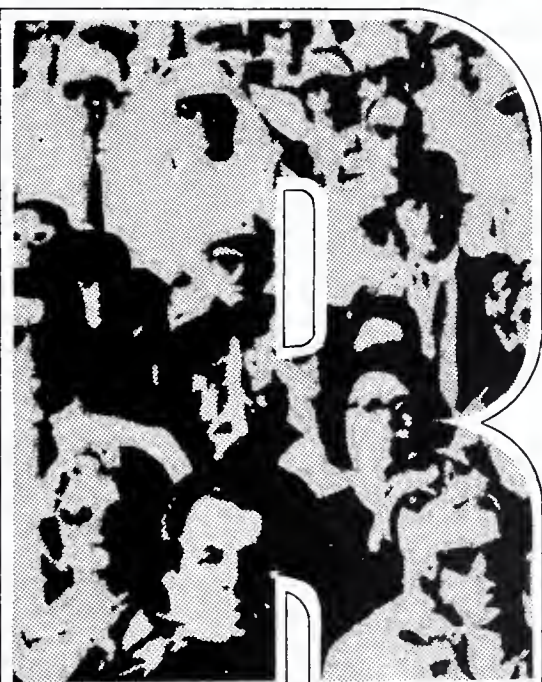
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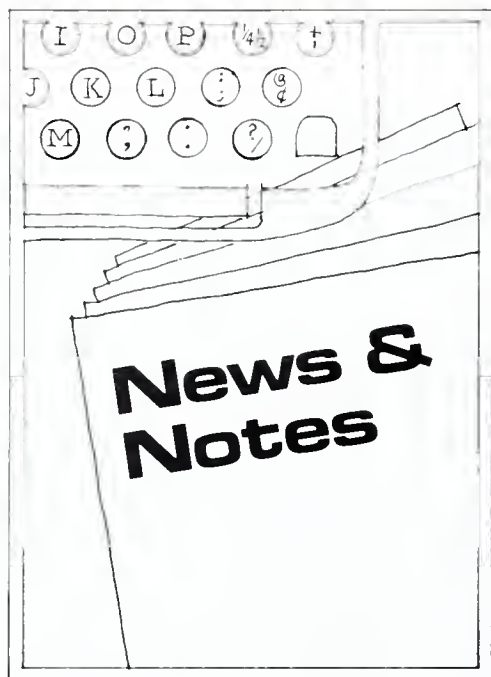
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HENRY N. YOKOYAMA, M.D.

Life in These Parts

My phone rang at 2:30 one morning. There was a frantic woman pleading for an appointment, because she was going "crazy."

"What's happened?" I asked sleepily.

"Oh, Doctor, I went to the bathroom and there is water all over the floor. I don't remember doing it, and I don't know when I did it. There is no one else here. I don't know what to do. I am so upset. Doctor!, you've got to help me."

"Sounds like you need a plumber, not a psychiatrist. Why don't you go check for a leak?"

She was not satisfied with that. We discussed the problem: the amount of water, what could have happened, what she might do, (including going back to bed and forgetting it until morning) and what could happen if she did nothing. I told her that it might be easier to deal with the water than her fear, which she was letting swamp her, and she finally hung up.

By this time, I was wide awake. I got up, roamed the house a bit, got some milk and found a dull book to read. I finally drifted off to sleep about 4:00 A.M.—only to be awakened a few minutes later by the phone ringing.

"Doctor, I just called to tell you that I am not 'crazy'. There was a leak in the plumbing and I called a plumber. I don't need you." She hung up.

Written by **Charlotte M. Florine**

All is not well in Kona... **James Mayer D.O.**, filed a \$750,000 slander suit against Kona physician **Thomas Mar** and the State...

John Keenan, chairman of the Medical Management Action Group, including 31 physicians and six medical professionals, wrote the Governor that its members will refuse to treat welfare patients under the Medicaid program because the fee schedules for Medicaid patients are grossly inadequate, and the last Legislature made no adjustment or major change in the financial support of the Medicaid system.

The Hawaii Heart Study findings reveal that persons with high alpha cholesterol levels have a lower risk of heart disease. Alpha cholesterol may be an additional tool for measuring the risk of heart disease according to a report by **Christian Gulbrandsen, Abraham Kagan** and **George Rhoads**. Another finding is that neck bruits are not necessarily ominous in persons free of stroke symptoms. This report was written by **George Rhoads, Jordon Popper, Katsuhiko Yano**, and **Abraham Kagan**.

The last plantation hospital in the islands, the 40-year-old 35-bed Waialua Hospital, will close in July or August. **Joseph Battista**, medical director, says the outpatient clinic, which sees about 100 patients daily, will continue.

For many years, a **Harold J. Ellison**, alias **Hal Ellis**, has been coming to the islands representing himself as a physician and injecting liquid silicone into the breasts and faces of gullible women. HMA exec secretary **Tom Thorson** has been on the alert for this fraud for at least 3 years, but could not find a patient willing to testify. When one woman who paid \$500 for breast augmentation complained later to Ellison about the lumps in her breast, she was reassured, "Don't worry, they are just bubbles." When the State Office of Consumer Protection finally filed suit, the man had already flown the coop...

The first annual fund-raising musical for the Children's Hospital Building Fund, co-chaired by maestro **Ed Kagihara** and **Ann Barbara Yee**, was held at the Sheraton Waikiki with entertainment by the familiar Floating Ribs (**Al Dennis, Ed Kagihara, Bob Lee**, and **Jerry Tucker**), the Tiki Tones (**Don Jones, Philip McNamee**, Mrs. **Dan Morgan**, and Mrs. **George Kimata**) and other non-physician professionals as well...

Locker Room Dialogue

(By **Dick Dennis**, our tennis-playing architect friend)

Doctor in grave tones says to patient: "You have 6 months to live." The patient goes home and later receives his bill. Patient calls doctor: "I can't possibly pay your bill in 6 months." Doctor: "Well, then, we'll give you 6 more months." (Dick says, "Never pay up your doctor's bill... Then, he'll have to keep you healthy.")

A small-town employer received the following Federal questionnaire: "Indicate the days of employee absenteeism broken down by sex." The employer replied forthrightly, "We have had employees broken down by alcoholism, but not from sex."

Professional Moves

This is the Year of the Hare by the oriental zodiac... And the hare treads softly without making waves in our medical community...

In April, GP **Stephen Davis** associated with the Kaiser Group, former Straub internist **David Eith** (our oft quoted baseball nut) joined **Dick Lam's** Industrial Medical Clinic, and eye man **Worldster Lee** opened his office at the Bere-tania Medical-Dental Plaza.

In May, internist **Mary Redford** rejoined the Medical Specialty Clinic at 1481 So King, GP **Thomas Dale McCowan** opened at Niu Valley Shopping Center, OB-Gyn woman **Eleanor Carlo Crim** associated with the Windward Medical Center at 407 Uluniu Street, Kailua, and internist **Erlinda Cachola** opened at Waiakamilo Square Building, 1405 No. King St.

Richard Cardines, State health officer for Kauai, says he quit because he was disenchanted with the new State administration. Dick is moving to Tahiti and before parting said, "I think we have a drifting, rudderless ship of state. We have mediocrity and a caretaker government. I do not care to be identified with that." In his 5½ years as Kauai's health officer, Dick had upheld rigid environmental standards to protect shoreline waters and to keep open spaces

continued on page 226

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from urbanization and has been criticized for allowing transients to live in crude shacks and tree houses.

Elected, Appointed & Honored

Former Senator **George Mills** was appointed to the National Advisory Committee for Juvenile Justice and Delinquency Prevention by President Ford... **Cesar DeJesus**, **Richard Mamiya**, and **William Goodhue** were named to the HMSA board of directors... **John Lowrey** was sworn in as a member of the Advisory Council for Comprehensive Health Planning... **Irwin Schatz**, nationally known U of M cardiologist, was finally named chairman of the Department of Medicine of the U of H School of Medicine where **Christian Gulbrandsen**, associate professor of medicine, has been acting chairman since 1973.

Hors De Combat

When former combat surgeon **Judson McNamara**, who probably knows more about bullet holes than anyone in the State, was quoted as saying, "Hollow point bullets increase the lethality of the wound, but I'm not sure they add to the stopping power of the bullet," a Frank Walton (apparently a law enforcement man with 39 years experience) discoursed at length on the stopping power test results of various types of bullets and added sarcastically, "Let's make a pact: we won't tell you what knife to use; you won't tell us what bullet to use."

Big Island osteopath, **James Mayer**, became the only remaining physician at Saigon's airport in the final flurry of evacuations in April after an 11-day volunteer trip to Viet Nam on "Project Babylift." Jim rescued 29 babies...

Children's Hospital pediatrician **Wayne McKinny** was also involved in "Project Babylift" and helped get out 219 babies from the An Lac Orphanage. Wayne was an administrator of two of Tom Dooley's hospitals in Cambodia between 1959 and 1960. He then served a stint in Laos, and was chief at An Lac between 1969 and 1970. Wayne is critical of the media, which paint the North Vietnamese occupation "as peaceful, orderly, without incidents, and without blood baths" for he has first hand sources reporting the opposite state of affairs in South Viet Nam.

Physicians Speak Up

The panelists for a public forum on aging were quoted as saying: ENT man **Ed Dierdorff**: "It's more important to

focus on the quality of life than to worry about how long it's going to be." Cardiologist **Mort Berk**: "There are simple things, such as heredity which you can't change... But if you have bad heredity, there are strikes against you, and there are things that can be done to modify the risks... However, everybody wants to prevent medical problems, as long as they don't interfere with their own special vices, such as smoking cigarettes..." Orthopedic moderator **Rowlin Lichter** feels that hormones can be quite helpful in maintaining bone strength in older people and added: "Sex is important. There's nothing wrong with sex in the 60's, 70's, 80's and 90's... You are as young as you feel." Psychiatrist **Byron Eliashof** agrees. Byron feels that "with effort and sometimes professional help, you can control negative, hopeless, despairing attitudes which can kill you... People have a lot more power than they realize to change the way they think and feel about things... That power should be used to develop a sense of integrity about one's life... It's important because old age is a time for leisure, reflection, reminiscence, an opportunity to look back and be able to accept oneself and one's life as having been OK, just the way it was... Be charitable with yourself and realize you probably did the best you could under the circumstances and with what you knew and had to work with at the same time. Try to accept it all and be at peace."

New district officer for the Big Island, **Andrew Sackett**, hopes that the decision by voters last election by a four to one margin not to fluoridate the Country's water will someday be changed. Andrew says, "Water fluoridation is the single, most worthwhile tool that can be used in dental care."

A regional perinatal health care unit will be developed through the efforts of Kapiolani Hospital, Children's Hosp. and the U of H Med School. **Sharon Bintliff**, associate professor of pediatrics and genetics says, "Every wanted child has the right to be born healthy... Let's not wait until the kid comes out with problem. Let's start way back there during the pregnancy."

When **S.G. Ross** wrote in a letter to the editor that the UH Med School was a luxury and that it would be cheaper to subsidize men and women of Hawaii at Mainland schools, **Terry Rogers**, Med School Dean, got his dander up: Terry pointed out that this school was not a luxury and that besides training physicians in a curriculum tailored for Hawaii's special needs, it provides a broad range of services that benefit the state. Terry said that it may be cheaper to send island students to mainland colleges, but they wouldn't be able to get in because of the acute shortage of openings. Besides it would be impossible for Island hospitals to train specialists because the accrediting boards have decided that by 1978 all residency training must be affiliated with a school of medicine. Hawaii's school is far less expensive than most since instead of operating a costly medical center, it conducts clinical training in community hospitals. Terry writes, "Meantime, Hawaii currently receives \$5 million a year in Federal grants for training and research, roughly

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equal to the State funded operating budget of the school. Instead of being a luxury, this school is a major asset, both to the health of Hawaii and because the funds invested in it provide a tangible cash return that means jobs, tax revenues, and economic activity for local businesses."

A. Richard Trockman was peeved about parking tickets and his letter to the editor is a classic: "There are many things wrong with parking tickets. One thing is the very impersonal nature of them. You come back to your car and find a ticket on it, but never know how it was put there or by whom or for what... No tickets should be given unless it is a person. You will have a lot more complaints if the newly hired rangers just go around giving tickets. This is just one example of the de-personalization which occurs in society which leads to a higher crime rate and much emotional agony. The individual feels powerless in front of the unthinking, unfeeling, uncompromising structure. He is no longer an individual under this system..." (Wot a philosopher! "Man's inhumanity to man," and that sort of stuff, eh?)

Entrepreneurs

HMSA beset by "the scourge of universal inflation and the rise of health care costs following the lifting of the federal freeze last May" was considering rate hikes... And it did...

"How doth the little busy bee improve each shining hour?" Pat Hunter, *Advertiser* staff writer, described the hilarious antics of retired orthoped **John Cooper**, who has turned bee keeper and who tried to retrieve a swarm of vagrant bees: "Cooper proceeded to scrape blobs of bees unceremoniously into the bag. Unfortunately, only about two thirds of them made it to their intended destination. The rest dropped onto Cooper's clothes and the ground below. Having recovered from their "smoking," the bees now were no longer confused. They knew exactly what they had to do—sting anybody in sight. Cooper jumped from the ladder with an agility astounding in a gentleman of his vintage, shouted, "Run like hell!" and streaked down the garden path and out the gate with a phalanx of bees hot on his heels..."

David Eith and **Dick Lam** have airport medical services which Dick initiated 5 years ago under contract to Pan Am. Two full time RN's provide medical services for the entire airport, and also retrieve luggage, make hotel reservations, set doctor's appointments, purchase nightclothes and sundries...

Public Relations

We are grateful to a group of dedicated Japanese-speaking physicians who have been regulars on two HMA sponsored Japanese radio programs. The older program has now run once weekly over 10 years on Station KOHO (1170) on Mondays 7:15 to 8:00 pm and the regulars now are **Noboru Akagi**, **Takakazu Fukumura**, **Keichi Goshi**, **Toshihiko Kawasugi**, **Naomitsu Tajima**, **Shozo Ogawa**, **Shigeo Natori** and **Kazushi Tanaka**. Another group covers Station KZOO (1210) on Tuesdays, 2:30 to 2:00 pm and includes **Hideki Namiki**, **Mitsuaki Suzuki**, **Emiko Sakurai**, **Shun-Kyung Liao**, **Keijiro Yazawa**, **N. Kominami**, **Tsuyoshi Yamashita**, et. al...

Only in the past few months have we become aware of yet another HMA-sponsored English medical radio program on KHVH (1040) on Thursday evenings between 7:30 and 8:00 pm. The program was formerly moderated by **Ron Pion** and now by psychologist **Ray Corsini**. The February panelists were **Garth Morimoto**, **Jim Navin**, **Mike Okihiro**. In March, **Bill Moore**, **Jim Penoff**, **George Suzuki**, **Ben Tom** were on. Then in April, we had **Charles Ching**, **Doris Jasinski**, **Max Levin**, and **Dudley Seto**. May speakers scheduled are **Harry Arnold Jr.**, **Abraham Kagan**, **Carl Boyer**, **William Shiraki**,

and **Don Char**. The format is simple. The panelist picks his own topic, discusses it for around 10 minutes and then "shoots the bull" with Ray Corsini while awaiting phone calls generated by the discussion...

On Spring Travel And Jogging (An essay by Charles Judd)

Studies by our marathon runner/cardiologist **Jack Scaff**, have shown that joggers are less likely to die from heart or blood vessel disease than non-joggers. The hundreds of people jogging on sidewalks and in parks attest to a local enthusiasm for this activity.

Jogging demands self-discipline, but this can be attenuated by group-jogging. Followers of Zen enjoy a sense of personal release from solitary jogging. (See Rohē, Fred: *The Zen of Jogging*, New York, Random House, Inc., 1974.) A jogger who misses his routine three or four times a week becomes restless. The compulsive jogger can be evangelical in his enthusiasm for he is like the smoker who has not smoked in several months.

Travel poses a problem for the jogger. He is away from his usual paths and fellow enthusiasts. His routine is disturbed by time changes, altered sleep patterns, and the gourmet meals of airlines and hotels.

An eight-day trip a few days ago to the East Coast presented a challenge to our jogging compulsion. After leaving Honolulu on a morning flight, our plane landed at San Francisco at 5:20 P.M., where we were scheduled to spend two nights in a motel near the airport. On that first afternoon, we donned our jog togs, crossed the treacherous Bay Shore Highway on one of the automobile lead-off ramps, and headed for a meadow which lies under a series of large electricity cable towers. Despite the bustle of the airport nearby and the commuters racing on the highway, the solitude of this greensward, which stretched for miles, provides a unique opportunity for jogging.

The next day found us in San Francisco, and we explored Golden Gate Park on the run. The sun was out, the temperature 55°, and the daffodils and tulips in early bloom. We were in a wonderland of unfolding vistas at each corner of sweeping green lawns 200 yards long, and of wooded paths beneath eucalyptus and maple trees.

On our third day, we lost three more hours in a flight to Connecticut and arrived after dark, so we took the day off. The fourth day found us at New Haven, and we circled the athletic fields of Yale University over a path several miles long. We scouted the football team in spring practice, and observed the soccer, lacrosse, and track teams in action.

The next day, we ran through residential New Haven. The jogger sees so much more than the motorist: people at their daily tasks, neighborhood dramas, local architecture, gardens, and fellow joggers. There are hazards, however. Leash laws often confine dogs to lawn strips immediately adjacent to the sidewalk. If one missteps, a shoe tarnished by dog litter presents an unwelcome stench upon returning indoors.

On the sixth day, we ran around the campus of the National Library of Medicine at Bethesda, Maryland. The blue-green grass had just been mowed, and was a carpet under the flowering white and pink dogwood trees.

Two final days in Philadelphia found us smack downtown in a hotel near Independence Hall. Five minutes of jogging got us to Logan Circle, from whence we struck out along the Ben Franklin Parkway, northeast, where there are plenty of park areas along the Schuylkill River. Old Ben would have loved jogging ("Eat not to dullness; drink not to insanity," etc.). Metropolitan jogging is inconvenienced by exhaust fumes, stop lights, and sidewalk crowding. We found an early hour, seven to eight A.M., the best time to run for Philadelphians are late risers compared to Hawaiians.

By this obsessive routine, we mobilized our fat stores daily, added perspective to our trip, and slept better. ■

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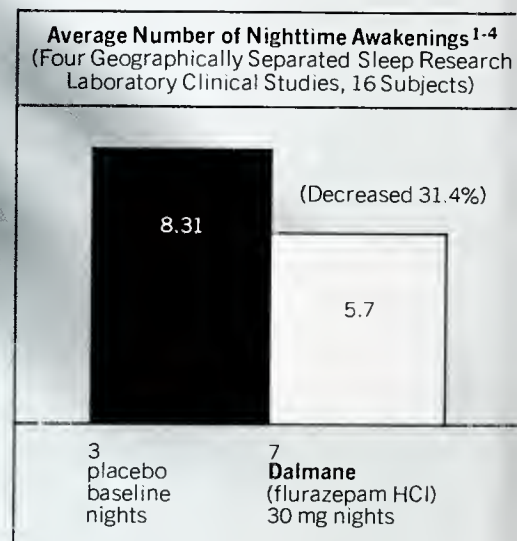
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4. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
5. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ

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Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly

or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

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Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications for use as follows:

Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus. **"Probably" effective:** For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding. **Warnings:** Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism).

If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.

Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens

should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.

Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:

nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating

breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)

breast tenderness and enlargement

reactivation of endometriosis

possible diminution of lactation when given immediately postpartum

loss of libido and gynecomastia in males

edema

aggravation of migraine headaches

change in body weight (increase, decrease)

headache

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hepatic cutaneous porphyria becoming manifest

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If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (e.g. osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

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Indications: *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium fre-

quently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy

patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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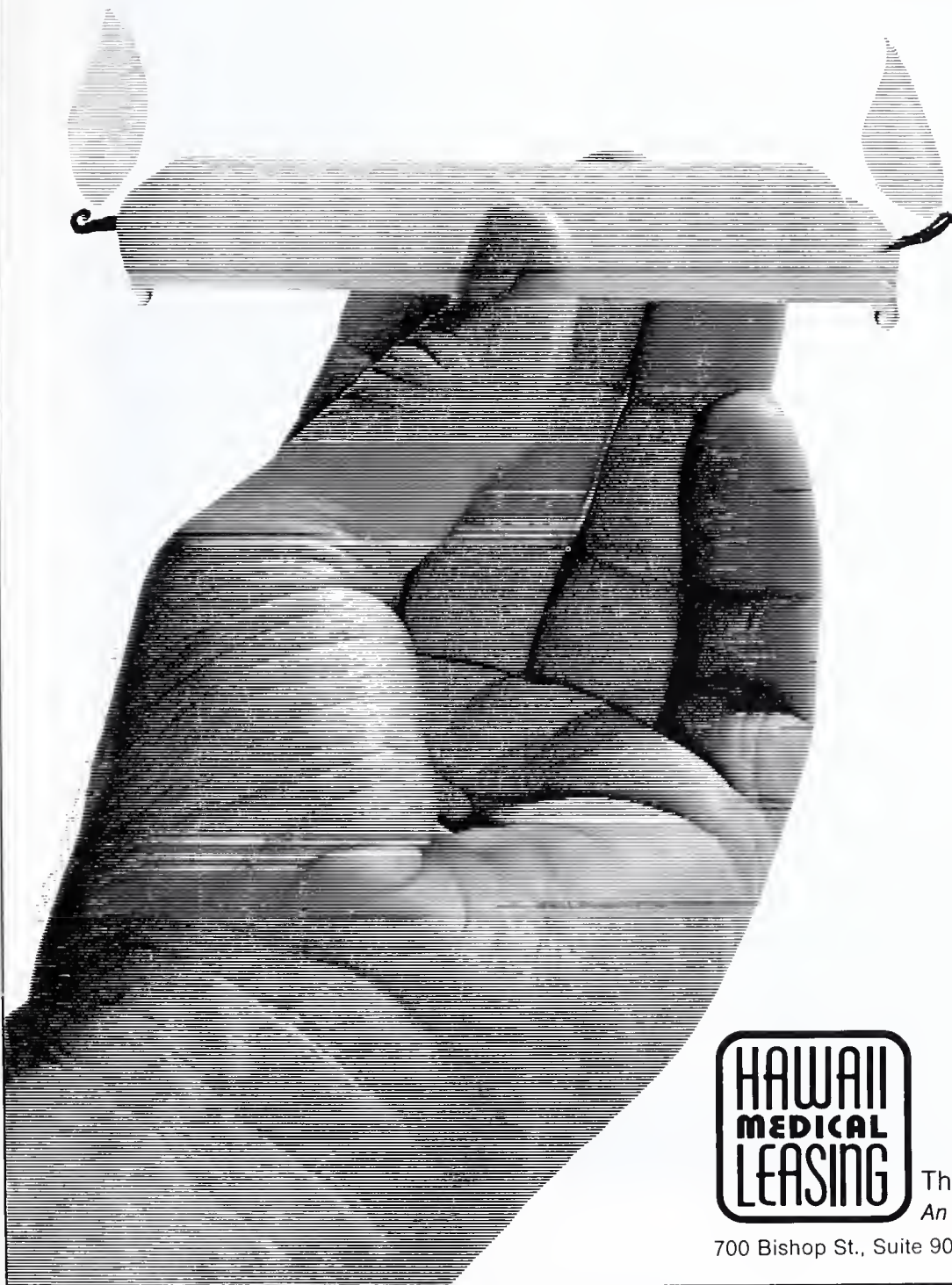
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CLINICAL CYTOGENETICS IN HAWAII— AN INTRODUCTION TO CHROMOSOME METHODOLOGY

DAVID T. ARAKAKI, D. Sc.,* *Honolulu*

● *Present day clinical cytogenetics had its foundation in a number of major technical advances which eventually enabled Tjio and Levan⁹ to make the first accurate count of human chromosomes in 1956. These investigators discovered that the correct chromosome number for man was not 48, as had been accepted for nearly 33 years, but 46. Only after this discovery could cytogeneticists and clinicians have a basis for determining what was normal in human chromosomes and, therefore, what was abnormal.*

Chromosome analysis can be the single most important test for screening or definitively establishing the diagnosis of certain common multiple congenital abnormalities such as Down's syndrome or Turner's syndrome.

Now some of the less obvious clinical entities, often associated with structural chromosome aberrations, may be detected by the newly discovered chromosome banding techniques. These include some of the mental retardation syndromes, birth defects, and "funny looking kids".

Historical Background

An important landmark of the early technical advances was that of tissue culture. The culturing of cells itself dates back to the turn of the century. During the first 50 years of the 1900's, however, it was pretty much an occult art, practiced only by a few select Ph.D.'s and M.D.'s. With the discovery of antibiotics and with qual-

ity control of the manufacture of synthetic nutrient media, the rigorous art of tissue culture became a fairly simple everyday laboratory procedure.

Tissue culture or, more correctly, cell culture became the source of cells in mitosis, the stage of the cell cycle when the cells divide and the chromatin material become visible as stained bodies or chromosomes. The development of cell culture techniques obviated the need to biopsy a natural dividing tissue such as the testis or bone marrow.

A major discovery in cytogenetic techniques was the finding that colchicine, when applied to a cell culture, arrested cells at metaphase, a phase in mitosis when the chromosomes display their optimal morphological characteristics.

As a result of colchicine treatment, hundreds of cells with clearly defined chromosomes can be prepared in a short time. These cells were then literally squashed between the microscope slide and the coverglass with one's thumbs. Despite the large number of metaphases, chromosomal analysis was still frustratingly difficult. When a cell was examined under the microscope, the chromosomes were a tangled mass superimposed upon one another in different focal planes, making it difficult to obtain an accurate count or to make a study of their morphology. This problem was solved by a fortunate accident. A laboratory technician at the University of Texas at Galveston intending to prepare a bottle of physiological saline mistakenly prepared a hypotonic solution. Applying this solution to the cells caused them to swell, separating the chromosomes.

The fruits of these technical advances came, of course, in 1956, when Tjio and Levan utilized the cell culture of a human embryonic lung tissue, colchicine, and the hypotonic treatment to

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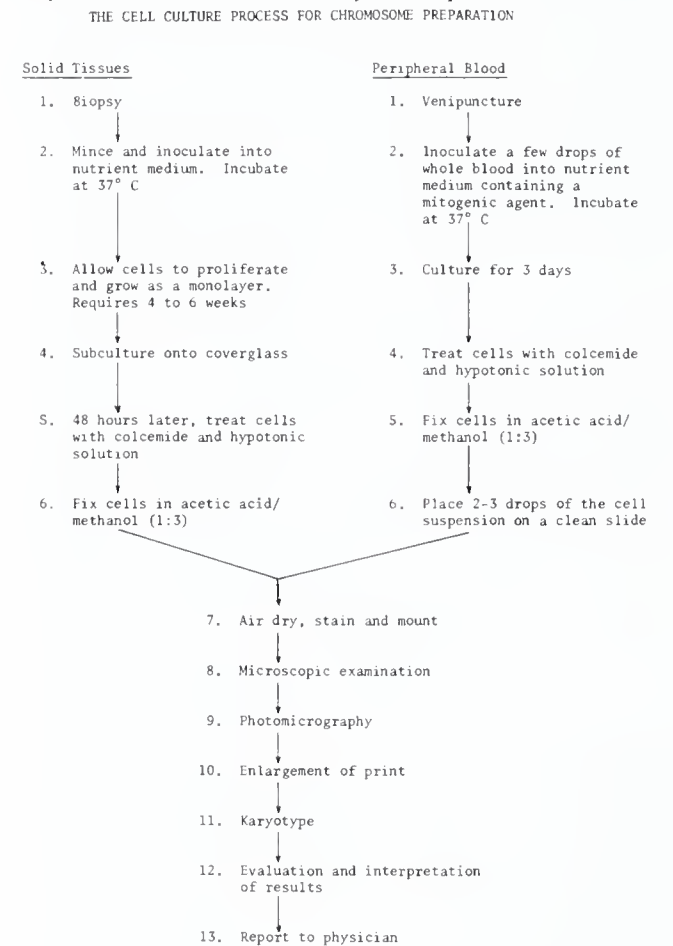
This work supported in part by a Public Health Service grant OGM No. 09-H-000147 through a contract with the State of Hawaii Department of Health and by charitable grants from the Bishop Trust Company.

make the first accurate count of human chromosomes.

Rapid progress was made in delineating certain well-established clinical entities as chromosomal defects—Down’s, Turner’s, and Klinefelter’s syndromes—and the discovery of the trisomy-18 and trisomy-13 syndromes.

The culture of cells from solid tissues usually requires 4 to 6 weeks before sufficient numbers become available for analysis. In the early 1960’s, it was discovered that phytohemagglutinin stimulated white blood cells to divide *in vitro* within 2 to 3 days.⁶ Moorhead and co-workers⁵ described a technique for preparing human chromosomes from 10 ml of sterile heparinized blood. Another innovation described by Arakaki and Sparkes¹ which required only a few drops of whole blood greatly facilitated the study of chromosome defects, especially in the newborn infant (Figure 1).

FIG. 1.—Diagram of the steps involved in processing a cell culture for chromosome analysis. From the time the specimen is received to the release of the final report, an average of 10 days for blood chromosome analysis and 5 weeks for skin fibroblast chromosome analysis is required.



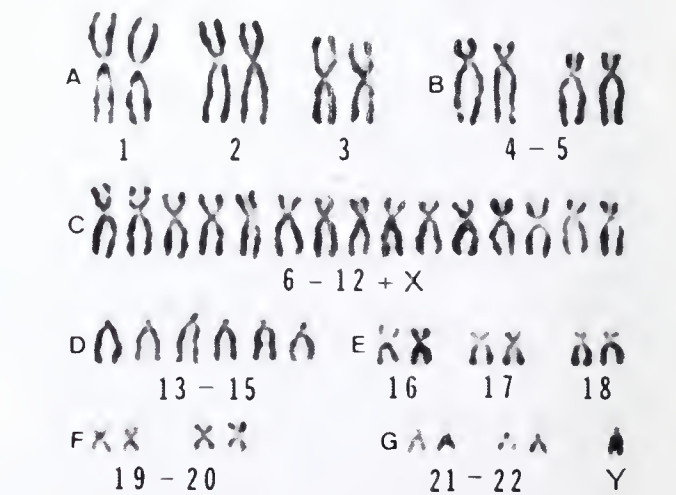
The opportunity to work with a suspension of dividing white blood cells, properly fixed in acetic-methanol, resulted in the adaption of another interesting and useful technique. It was found that chromosomes could be fixed and mounted on a slide by a one-step air-drying process⁸ resulting in well separated chromosomes lying in a single plane (Figure 2).

FIG. 2.—The chromosomes of a human lymphocyte as seen at metaphase after treatment with colcemide and hypotonic solution.



Following these techniques, the chromosomes are stained and prepared for the analysis. The slide is scanned under the microscope for suitable metaphases, and the chromosomes within a number of metaphases are counted to establish a diploid chromosome number for the patient. An experienced cytogenetics technician can readily detect gross chromosomal aberrations or changes in chromosome number. A few selected metaphases are photographed in order to construct a karyotype. A photographic enlargement of the chromosomes is cut apart so that each of the chromosomes can be paired with its homologue (Figure 3). The chromosomes are then arranged in descending order of size and classified into Groups A to G and each pair is numbered 1 to 22. The sex chromosomes are labeled X

FIG. 3.—Karyotype of a normal male complement from the metaphase shown in Figure 2. On the recommendations of the Denver Conference (1960),³ the autosomes are paired as nearly as possible and serially numbered from 1 to 22 in descending order of length. The sex chromosomes are referred to as X and Y. The identification of individual chromosomes is based on size, position of the centromere and other morphological features. By this scheme, the autosomes fall into seven recognizable groups labeled A to G (London Conference, 1963).⁴ Each group consists of chromosomes of similar length and morphology and is distinct from other groups.

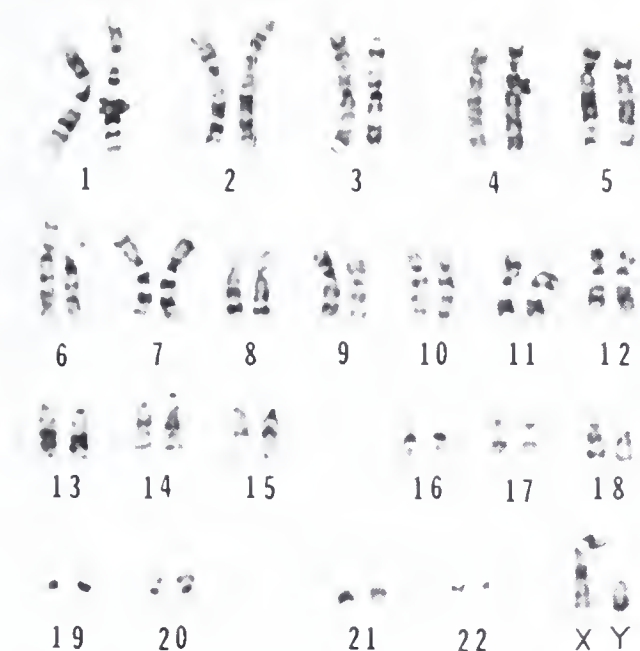


and Y. Any gross deviation from the normal karyotype can thus be easily detected in a patient’s karyotype.

Chromosome identification

Perhaps the greatest discovery in chromosome technology has been the banding technique which imparts a characteristic banding pattern to each of the 22 pairs of autosomes and the sex chromosomes (Figure 4). Not only can the chromosomes be definitively identified and paired, but the points of chromosome breakages and the subregions of chromosomes can be described (Paris Conference, 1971).⁷ This band-

FIG. 4.—Karyotype of a normal male prepared by the banding technique. In our laboratory the chromosomes are treated with a solution of proteolytic enzyme or urea which induces the banding patterns. Each chromosome consists of a continuous series of light and dark bands. The identification of individual chromosomes is now based on the unique pattern of bands which characterize each pair of homologues. Deviations from the normal pattern of bands may indicate a chromosomal deficiency, duplication or other chromosomal aberrations.

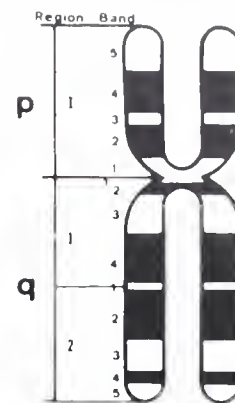


ing technique has made it possible to detect small changes in chromosome structure, to identify derivative chromosomes of a translocation, and to detect previously unidentified abnormal chromosomes which mimicked normal chromosomes in morphology.

The Chicago Conference (1966)² and the Paris Conference (1971)⁷ have established a standardized system of nomenclature to describe the chromosomes to improve communication in human cytogenetics. The following is a brief description of the mechanics and examples of a few simple symbolisms a clinician may encounter in a cytogenetic report. The reader is referred to the Paris Conference (1971) for a detailed discussion of the nomenclature.

Each human chromosome is divided by the centromere into two arms. The short arm is designated as *p* and the long arm *q* (Figure 5). There are major bands and other landmarks which subdivide the arms into regions. Each region is numbered consecutively from the centromere outwards, and is further subdivided as

FIG. 5.—Diagram of chromosome 11 showing the banding pattern and identification of the major regions and bands.



bands which are also numbered consecutively and distally towards the end of the arms. Thus the two regions adjacent to the centromere are labeled "1" in each arm, the next, more distal regions, "2", and so on. Within a region, the bands are 1, 2, 3, etc. An example of the band nomenclature, 11q14 indicates chromosome No. 11, long arm, region 1, band 4.

A + or - sign is used to indicate an additional or missing whole chromosome when the sign is placed before a symbol. For example, a female Down's syndrome is denoted as 47, XX, +21, meaning there is an extra chromosome No. 21.

A + or - sign is used to indicate an increase or decrease (as in a deletion) in length of the chromosome when the sign is placed after a symbol. An example is the Cri du Chat syndrome, 46, XX, 5p-.

A translocation is denoted by a *t* followed parenthetically by the derivative chromosomes. An example is 46,XX,-13,+t(13q21q). This symbolism indicates a female Down's syndrome due to a translocation 13-21 chromosome.

Analysis guidelines

Cytogenetic tests are available at the Genetics Laboratory at Kapiolani Children's Hospital. Sterile samples of heparinized whole blood or bone marrow (1-2 ml), skin or other tissue biopsies (1x2 mm), or amniocentesis (10 ml) are accepted for chromosome analysis. The routine chromosome analysis is performed on lymphocytes, which requires only 3 days for culture and another 5 to 7 days for microscopic examination, karyotyping and evaluation. The karyotypes are reviewed together with the clinical information sent by the referring physician.

A skin biopsy is sometimes requested to confirm a case of mosaicism. The analysis on skin fibroblastic cells may require 4 to 6 weeks or longer depending upon the time it takes to grow sufficient cells for an analysis. With amniocentesis there is the infrequent problem of not obtaining a sufficient number of viable cells to produce clones suitable for analysis. In such instances, repeat amniotic taps may be required.

While there are many potential obstacles in

doing a chromosome analysis, including microbial contamination or equipment failures, most have been eliminated. The major goal, of course, is to obtain dividing cells so that the chromosomes can be visualized and an analysis performed.

Summary

A historical background on the technical ad-

vances in the study of chromosomes and their incorporation into human clinical cytogenetics is presented. The banding of the chromosomes permitted the identification of individual chromosomes with greater precision than previously possible. A discussion of the new nomenclature is presented to acquaint the clinician to the jargon of present day clinical cytogenetics.

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Is a virus responsible? . . .

PREVALENCE OF BEHÇET'S SYNDROME IN HAWAII

With Particular Reference to the Comparison of the Japanese in Hawaii and Japan

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● *Behçet's syndrome is a serious entity and a major cause of blindness in Japan. A survey was conducted to determine the prevalence of this recurrent disease among the Japanese and other ethnic groups residing in Hawaii. Based on the known prevalence of this syndrome in Japan, it was expected that about fifteen cases would be reported among the Japanese in Hawaii. No cases of Behçet's syndrome were identified. This finding suggests that the causative factors of the syndrome are primarily environmental rather than genetic.*

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Behçet's syndrome is characterized by recurrent hypopyon iritis, cutaneous lesions, and recurrent ulcerations of the mouth or genitalia. The syndrome is found more in males and young adults. It is a serious entity which can lead to blindness, thrombophlebitis or neurologic complications, such as signs of meningeal irritation, seizures and multiple cranial nerve palsies.¹ Approximately 10-25% of patients with Behçet's syndrome develop neurologic findings which have led to death within one year in two-thirds of reported neuro-Behçet cases.²

Although this syndrome occurs infrequently among inhabitants of most parts of the world, it is not uncommon in Japan. In the recent Behçet's Disease National Epidemiological Survey in Japan, the prevalence of the syndrome was

6.3 cases per 100,000.³ Furthermore, it was estimated in 1969 that Behçet's syndrome was the cause of blindness for approximately 16% of the acquired cases of blindness in Japan.⁴

The cause of the syndrome is essentially unknown. With the migration of large numbers of Japanese to Hawaii many years ago, a unique opportunity has been provided to search for clues with respect to the etiology of this recurrent disease. By comparing the prevalence of Behçet's syndrome between the Japanese in Japan and Hawaii, it is possible to determine if this syndrome is primarily caused by environmental or genetic factors. In addition, the prevalence of this disease can also be ascertained among other ethnic groups living in Hawaii. Only one case of Chinese ancestry has been reported and this syndrome has yet to be described in Hawaiians or Filipinos.⁵ Cases among whites have been reported, but on an infrequent basis.

Methods

A survey was conducted to determine the prevalence of Behçet's syndrome in Hawaii. In order to compare the findings of the Hawaii Japanese with their counterparts in Japan, the following guidelines for the major manifestations of Behçet's syndrome, adopted by the Japanese national survey,³ were utilized:

- 1) Oral manifestations: Recurrent aphthous and ulcerative changes in the oral mucosa.
- 2) Cutaneous manifestations:
 - a. Erythema nodosum-like nodule
 - b. Subcutaneous thrombophlebitis
 - c. Non-specific skin irritability
 - d. Folliculitis, papulo-pustular lesion and acneiform nodules
- 3) Ocular manifestations:
 - a. Iridocyclitis appearing as relapsing hypopyon iritis and/or serous iritis
 - b. Retinochoroiditis
- 4) Genital manifestations: Ulcers of the genital region.

The classification of Behçet's syndrome was based on the following:

- 1) Complete type: The four major manifestations are found at one time or at different times in the clinical course.
- 2) Incomplete type:
 - a. Three major manifestations are found at one time or at different times during the course of the disease.
 - b. Typical ocular manifestations (relapsing hypopyon iritis or retinochoroiditis) and one extraocular major manifestation are seen.
- 3) Probable type: Two major manifestations appear at one time or at different times during the course of the disease.
- 4) Possible type: Only one major manifestation is present.

For purposes of this survey, the diagnosis of Behçet's syndrome will be limited to the complete and incomplete types.

In Hawaii, brief questionnaires with a description of the syndrome were sent to every dermatologist, internist, obstetrician-gynecologist, ophthalmologist and otolaryngologist practicing in the State of Hawaii in 1973. These physicians were selected because they would most likely treat a patient with Behçet's syndrome in the community. The specialists were asked if they had seen any cases compatible with Behçet's syndrome from January, 1969, to December, 1973.

The number of contacted physicians by each specialty is given in Table 1. Of the physicians who were contacted, 95% responded to the inquiry, 66% by mailing back the questionnaire and 29% by telephone response. A second detailed questionnaire was sent to physicians who had seen suspect cases of the syndrome to obtain more information about the cases.

TABLE 1.—Percentage of Respondents among Physicians by Specialty

Specialty	Number Contacted	Respondents No.	%
Dermatologist	19	17	89.5
Internist	114	108	94.7
Obstetrician-Gynecologist	72	69	95.8
Ophthalmologist	*39	39	100.0
Otolaryngologist	27	25	92.6
TOTAL	271	258	95.2

*Includes two physicians who specialized in ophthalmology and otolaryngology.

In order to determine the expected prevalence of Behçet's syndrome among the Japanese residents of Hawaii, data from the Behçet's Disease National Epidemiological Survey of Japan³ were utilized. This survey was published in 1974 and was conducted in 46 prefectures of Japan. Hospitals were systematically canvassed to determine the prevalence of this recurrent disease over a one-year period. Identified cases were reviewed to avoid duplication which could occur when the same patient was admitted to more than one hospital during the observed period of time.

Results

The total number of residents in Hawaii by race is given in Table 2. This is based on the

TABLE 2.—Distribution of Hawan Residents by Race Based on 1970 U.S. Census Bureau Data

Race	Number
White	298,160
Japanese	217,307
Filipino	93,915
Chinese	52,039
All others	107,140
TOTAL	768,561

U.S. Census Bureau data for 1970. Among the physicians who responded to the first questionnaire, seven reported cases possibly compatible with the syndrome. Upon further inquiry the suspect cases did not fulfill the necessary criteria and none of them had any ocular symptoms. Therefore, no cases of Behçet's syndrome, complete or incomplete, were identified in Hawaii for the designated five-year period.

It is estimated that approximately 80% of the Hawaii Japanese originated from six of the 46 prefectures of Japan.⁶ The prevalence rates of Behçet's syndrome among residents of these six prefectures is given in Table 3. Based on these

TABLE 3.—Prevalence of Behçet's Syndrome in the Six Most Common Prefectures of Origin of Hawaii Japanese

PREFECTURE	NO. OF CASES/100,000
Hiroshima	6.2
Yamaguchi	6.6
Kumamoto	6.9
Niigata	8.1
Fukushima	8.8
Fukuoka	8.2
*TOTAL	7.6

*Based on the total population of the six prefectures.

data from the Japanese national survey, approximately 15 cases of Behçet's should have been detected among the 217,000 Hawaii Japanese if similar prevalence rates prevailed in the migrant Japanese population. Because no cases were observed in Hawaii, this difference in the prevalence of Behçet's syndrome between the two Japanese populations is a very significant one with a $p < .001$ by Poisson distribution.

Discussion

The high level of cooperation of Hawaii physicians who are most likely to be seen by patients with Behçet's syndrome makes it improbable that diagnosed cases were not identified in this survey. Although the possibility

exists that some of the responding physicians failed to recognize an actual case of Behçet's syndrome among their patients, the relatively distinct features of the syndrome make this an unlikely event.

The marked difference in the prevalence of the syndrome between the two Japanese populations suggests that the etiological factors of this syndrome are primarily environmental rather than genetic. If genetic factors prevailed, a number of cases should have been identified in the migrant Japanese population of Hawaii. The prominence of the environmental role is further supported by the lack of cases of Behçet's syndrome among other racial groups in Hawaii, which suggests that the causative factors have not gained a foothold in Hawaii's insular setting.

Compatible with the environmental hypothesis is the impression of several investigators that a virus is responsible for Behçet's syndrome. There have been two principal claims that such a virus has been isolated. Sezer in Turkey claimed that he identified a virus from patients with Behçet's syndrome and reproduced the disease in mice and rabbits.⁷ Evans et al grew a virus from the cerebro-spinal fluid, aqueous and cerebral tissue of a victim of the syndrome, but were unable to infect any laboratory animal with it.⁸ Although these studies are far from conclusive of a viral etiology of the syndrome, this investigation suggests that further efforts are needed to pursue viral as well as other environmental factors rather than genetic ones to identify the cause of Behçet's syndrome.

Acknowledgment

The authors wish to thank the members of the Hawaii Medical Association and its past president, Dr. Thomas P. Frissell for their invaluable assistance.

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H. TOM THORSON

Accreditation Kapiolani Community College—

The program for training Medical Assistants at Kapiolani Community College has been given accreditation. Accreditation was given through the American Association of Medical Assistants. Representatives of HCMS and HMA participated in the accreditation review process.

New Officers for HAAMA—The Hawaii American Association of Medical Assistants elected new officers for 1975-76. They are, President, Janet Nakahara, CMA-AC; President-elect, Melvina Nomura; Vice President, Pat Callahan; Recording Secretary, Marilyn Santiago; Corresponding Secretary, Debra Barcena; and Treasurer, Linda Rego. Advisors are R.V. Sloan, M.D., Mary Lou Hefley, M.D., and Claude Caver, M.D.

New Appeals Injunction—HEW who was enjoined by the AMA in Federal Court from proceeding with their Utilization Review regulations to be effective July 1, has appealed the decision. In the meantime the HEW is apparently going ahead almost as if nothing had happened and is urging hospitals to implement the procedures that were set up in the regulations. It would be interesting if they picked up the whole organization on a contempt of court charge. It would take a large jail. Also it might be a good idea.

Professional Liability Insurance—Hearings began in June in Congress before the House Health Subcommittee on the financing and operating of insurance firms. The major target of the hearings was on rates. AMA and others stress support for legislative action on local (State) level rather than at the federal level.

CHP approves certificate of need for Waianae and recommends additional funding for Waianae Health Center. HMA received proposal two days before the hearing with no time to comment.

AMA has requested HEW to withdraw criteria for determining "reasonable" charges under Medicare. Proposal would tie income limit to changes in workers' income. The 75th percentile for reimbursement would be continued with bases established in 1973.

Human Chorionic Gonadotropin in weight reduction programs—HMA policy relative to the use of HCG in weight reduction parallels the policy statement of the AMA to the effect that—(Res. 44-C74)

"That the American Medical Association adopt a strong policy in opposition to the use of HCG in weight control programs."

The decision is based on findings of controlled studies. FDA also has published in the Federal Register a disapproval of use of HCG in weight control clinics.

AMA Annual Meeting Notes—Big issues were the AMA dues, PSROs, liability insurance, AMA restructuring, AMA attack on HEW rules, etc.

Dues were increased by the House of Delegates based on the interim report of the House committee appointed in Portland in 1974. The interim committee recommended the increase to \$250, along with some specific suggestions for changes in AMA structure. When the reference committee considered the report they returned a recommendation to the House that the dues be set at \$225. The New York Delegation suggested an amendment to \$200, but when the rhetoric subsided and the full report was considered, the House of Delegates voted almost unanimously to go for the higher figure of \$250. The overall report included a number of housekeeping changes including the elimination of some publications such as PRISM, transfer of specialty publications to the specialty societies, reduction of staff to 824 from 1042, elimination of a number of Councils, Commissions, and Committees, and a number of other housekeeping economies. This rearrangement was fought through in very stormy sessions but in the end the delegates were convinced that they had taken the proper action.

The June 23/30, 1975 issue of the AM News will carry details.

Max H. Parrott, M.D., Portland, Oregon, was installed as the AMA's 130th president. Richard E. Palmer, M.D., Alexandria, Va., was named president-elect and George W. Slagle, M.D., Battle Creek, Mich., was elected vice president.

Re-elected by acclamation were Tom E. Nesbitt, M.D., Nashville, Tenn., as speaker of the House, and William Y. Rial, M.D., Swarthmore, Pa., vice speaker. Re-elected to three-year terms on the Board of Trustees were Jere W. Annis, M.D., Lakeland, Fla.; Robert B. Hunter, M.D., Sedro Woolley, Wash.; and Joe T. Nelson, M.D., Weatherford, Texas. Elected to a three-year term was Joseph F. Boyle, M.D., Los Angeles. Lowell H. Steen, M.D., Hammond, Ind., was elected to fill the unexpired term of Dr. Palmer.

Officers Meet to establish policy on multiple approaches to legislation related to malpractice problems. *Ad hoc* committee is preparing a package of legislation subject to policy approval which will be submitted to the legislature in 1976.

Mutual Insurance Company being studied by the committee as well may offer solution to coverage problem. Whether or not such a plan is feasible is yet to be determined. Questionnaires are being sent to all members to assess the market potential as there is no doubt that we are marginal in size and without full support of the membership, the project will not fly. AMA is forming a reinsurance company to work with state associations to develop "captive" insurance companies for malpractice insurance.

Crippled Children committee is reviewing plan for changes in the plan for the mentally retarded.

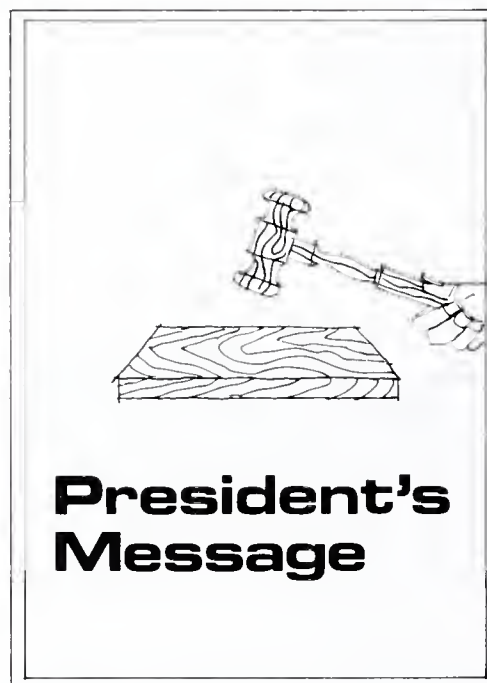
HMA resolution submitted to AMA relative to Medical Officers of the Trust Territory and American Samoa was referred to the Council on Medical Service for study. Recent plebiscite in Marianas complicates matter because if the Northern Marianas becomes a Commonwealth of the US the whole picture changes in regard to the PSRO operation. Up to now HEW has refused to consider the Medical Officers as professionals in spite of the fact that the major portion of professional service is rendered by this group who work side by side with the MDs. It is a complicated problem and will become more so when Commonwealth status is extended to the Marianas. Thirty-seven of the fifty-four doctors are Medical Officers—only seventeen MDs in the entire territory.

Senator Inouye at HCMS Meeting discussed malpractice insurance problems from the point of view of congress. He has introduced two bills in congress, one that may be termed a no-fault bill and the other providing for arbitration. Both bills have their drawbacks and the Senator explained that they were introduced primarily

to bring to a head the need for the various states to resolve the problem. He said that he was sure that we did not want HEW administering the program.

He urged action on a broad front through the insurance industry, the legal profession, and the medical profession.

Standing room only was the order of the day at the meeting—more than 375 were in attendance.



The time has come when a more meaningful President's Message can be made. The last six months has been filled with many unforgettable experiences, frustrations, decision making, and planning.

Communication. As originally promised to you, at the inaugural dinner, the main goal and objective of this President was to improve the communications, both internal and external, of the Association. Perhaps the fact that this is only my second report to you since assuming office negates that stated goal but this promise was made in all sincerity. Communication, regardless of who or what is doing it, was and still is my main objective.

For internal communication purposes, we revamped the HAWAII MEDICAL JOURNAL, both from a physical standpoint and in its content, to more accurately comply with the stated communications goal. The HMA Newsletter now appears in each issue along with special HMA committee reports, HMA council meeting minutes, continuing medical education information, HMA activities, Hospital News, and other pertinent features. We felt that a new direction for the JOURNAL was necessary and right. It may need refinement, but as time passes we feel confident that the JOURNAL will become more and more important to all of us in fulfilling this need for a sound communication media and still be fiscally sound.

Externally we have made giant steps in being able to establish a sound working relationship with the Governor's office, we are getting fair hearings at the legislature and responsive cooperation at the various government offices and departments. Our public relations may need strengthening, but overall we still enjoy a great deal of respect from the community at large. Overall I would sum up the first six months as being pretty much on target insofar as meeting our planned communication goal and objective for 1975. What is necessary is more internal communication to you—the members of the HMA. The following are some of the more troublesome areas we have addressed ourselves to during the first six-months.

Professional Liability. An *ad hoc* committee was formed to study this very complex issue. At this time it seems that the issue can best be resolved at a local, state level rather than through federal legislation. Other parts of the issue (and there are many many parts) receiving attention by the committee include revisions in the state tort system, various alternative methods of settlement, and the possibility of a mutual fund insurance program. It is extremely important that this committee be given every opportunity to discharge its main function—to recommend policies and actions to Council so that organized medicine, at least in Hawaii, speak through a unified and strong single voice. Membership input should be directed to this committee.

Site. After many different committees and groups, years of diligent study, proposals accepted and rejected, it seems that, for the near future at least, we will continue to house ourselves in our beloved Mabel Smyth Building. Other possibilities were studied in depth, but the advantages of staying put, with some renovation, far outweighed the advantages of a complex move.

Legislative Review. The past legislative session could be considered a fairly productive session insofar as the profession was concerned. Many key bills were passed and much groundwork accomplished for the coming session. The responsiveness of the Governor's office, legislature and government agencies to our needs seems to be improved. This was especially obvious in the amount of help we were able to extend to the Medical School during their "moment of truth", in the passage of a "stop-gap" measure for the pooling of a joint underwriting program to assure availability of professional liability insurance coverage, in the extension of the immunity law for peer review committees which will allow them to communicate with other committees and with governmental agencies such as the Board of Medical Examiners, in the development of a permanent statewide school health program, and in an amendment to

the minor's consent law which provides that the physician treating a minor for venereal disease may at his discretion inform the parent or guardian of said minor.

AMA. Despite the rash of publicity written by the prophets of doom, it seems painfully obvious that the central issue at the recent AMA meeting centered solely around the accountability and credibility of the AMA's Board of Trustees. This is a good and a healthy sign that the profession is alive and well—certainly not about to expire. The raise in dues has caused some concern among our fellow members, but if AMA is to become more aggressive, responsive and active, this dues increase must be met by all of our profession. At the HMA annual meeting in October, I feel sure that the issue of unified membership in the county society, HMA and AMA will arise. This issue should be honestly and objectively resolved by our House of Delegates.

Physicians Action Group. The creation of this group is to be commended. While our official position agreed in principle with this group, we did not always agree with their methods. We feel, however, that the group served a purpose in emphasizing a problem to both the legislature and the community. While no real increase in DSS fees was granted during this session, the legislature was put on record that this will be a major issue in the next session. The HMA's active support of the Dental Association's successful efforts for a DSS fee increase cannot but have a beneficial effect on our own goals.

PSRO. Briefly, the Pacific PSRO, Inc. is now officially in a 4-month cost overrun extension of its original planning contract, which was extended for six months. The basic reason for all of the extensions and delays, and we believe that our 4-month cost overrun will be followed by another 6-months planning extension, is the inability of HEW to persuade Congress to fund the PSRO program. All of our extensions were made upon the advice of HEW. Final plans for Conditional Status are dependent upon HEW's input on a review of our draft. They have not submitted this to us. The earliest date for in-house review will probably not occur until mid 1976.

Continuing Medical Education. A more important element in our professional lives. The HMA has been accredited as the agency to approve continuing education programs toward credits to qualify for the Physicians Recognition Award of the American Medical Association. This award is becoming the standard against which continuing education requirements are measured. It may well become the substitute for mandatory continued education and recertification. Already some states have moved in the direction of requiring continuing education for relicensure.



Patient! Heal thyself!

It seems that whatever the government touches turns to gold—but not in the Midas sense. The “touch” is costing the taxpayers money!

Government intervention in the name of cost control not only has resulted in an accelerating upward spiral of the costs of medical care, but, more seriously, it has had an adverse impact on the availability and the quality of that care. (The best news we have heard in a long time is Judge Julius Hoffman's—of Chicago-7 fame—injunction against the DHEW to cease and desist from interfering with the delivery of medical care; the AMA had challenged the validity of the utilization review rules & regs of the Department.) To begin with, government's sponsorship of programs such as Medicare and Medicaid has encouraged people to become demanding of and dependent upon these programs. The proof of the veracity of this statement lies in its obviously desperate attempts recently to curtail the benefits accorded by these programs and to clamp down on usage. Unfortunately, these attempts are misdirected against physicians and hospitals—the chief providers of care—by the threat of withholding support funds and payments for services rendered, AFTER the benefits have been provided to the old and to the poor. This borders closely on trespass on the right guaranteed by the 13th amendment of the Constitution—the prohibition against involuntary servitude.

So, why doesn't the country; why don't the people and their representative government face up to reality? Let's try some other way of keeping the costs of medical care within bounds.

On June 28, at one of the bimonthly meetings of the Hawaii Chapter, American Academy of Family Physicians, guest speaker Ah Quon MacElrath, social worker for the ILWU, raised a lot

of hackles by lambasting us physicians in general (not just us generalists!) for not providing people with the medical care they want, not providing it WHEN they want it, and not providing it at reasonable cost, particularly to the poor and near-poor. She reiterated the oft-repeated cliché that doctors are crisis-oriented rather than directing their efforts at keeping people well, and that they are profit-oriented; that hospitals are self-aggrandizing corporations fiercely competitive with each other. “That's why we have had to have Certificate of Need legislation,” said she, forgetting that to reduce availability is a good way to reduce costs, but that benefits, too, are thus denied to many who are equally eligible but cannot get in to the programs such as renal dialysis.

The evening did not end up in a riot, however. Ah Quon tempered her remarks by admitting her provocative tongue was in her cheek. Moreover, she got down to some real brass tacks by advocating a “new direction” in health care. Enlisting our interest and our participation as a profession, she proposed that the people/patients be educated in self-help, so that “the 60% of the patients you claim are in your offices for no real good reason, not for any serious illness, could be educated to stay away from expensive doctors and hospitals.” She admitted that the burden of this educational effort should fall on the shoulders of the people themselves—that they should monitor their own predilections for eating too much of the wrong kinds of food, for smoking too much, drinking too much, driving too fast, etc.—and that preventive health care begins at home.

Instead of being negative in our attitude towards the many and varied proposals of a socialistic nature for national health care, perhaps the medical profession needs to take the lead in “Patient Health Education”. The least we can do is to offer to advise and consent when the social health care planners sit down to work out the means to accomplish this objective.

J I F R

Solidarity Forever! Support Your AMA!

The AMA has set itself a course that should lead to a restoration of its fiscal health and vigor within the next two or three years. The House of Delegates, meeting in Atlantic City in June, overwhelmingly endorsed an increase in dues to \$250 a year. The states of New York and Oklahoma urged a \$200 figure, and the Reference Committee recommended \$225, but the states of Illinois, Ohio, Michigan, Kansas, Georgia, Florida, Arizona, and Texas urged adoption of the figure recommended by the Board of Trustees: \$250. The vote to approve this figure was not far from unanimous.

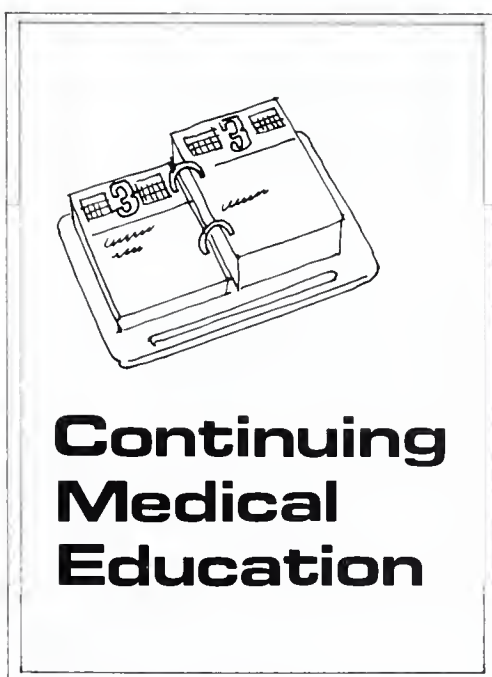
This is a big increase in dues; it more than doubles them; but apart from its being really

inescapable, it is still a bargain. Many labor unions charge more, and we may as well face bravely the fact that we physicians need a union as well as a scientific forum, in these troubled times. Despite the existence of 2 or 3 splinter groups of doctors, mostly of the ultra-right-wing persuasion, we have no national organization that can represent us half so well as our own AMA. It has already successfully sued the Federal Government in our behalf. The recent accession to the Board of Trustees of such men as Frank Jirka of Illinois, Joe Boyle of California, Dan Cloud of Arizona, Joe Nelson of Texas, and others, and of Max Parrott to the presidency, and the election of Ray Holden of Washington, DC, to the chairmanship of the Board, augur well for the top level guidance we'll have in the coming years.

Savings have been effected across the board by reduction of staff and other economies: *Prism*, a beautiful but extremely expensive magazine, is to be disposed of by the trustees, and all other publications except *JAMA* and *AMNews* will be distributed on a subscription basis. Some specialty journals may be turned over to the appropriate specialty societies for publication by them, or discontinued (only the *Archives of Dermatology* pays its way fully).

It is our firm conviction that every responsible physician has a duty to belong to and support the American Medical Association as his national voice in matters affecting health legislation, health profession controls, health insurance, hospital insurance, Medicare, graduate medical education, and so on. If we don't speak with one voice in these matters, there are plenty of nonmedical organizations eager to step into the gap!

HLAJR



Wilcox Hospital at Lihue was granted two year accreditation of its CME program at the June meeting of the HMA

Continuing Medical Education Committee meeting. Its AMA Category 1 programs appear below. Congratulations are due for a well-organized effort. The program was surveyed by Ray Huffman, M.D., Chairman; and Nadine Bruce, M.D. and Verne Waite, M.D.

Kaiser Hospital will be surveyed July 8, and Wahiawa Hospital has completed all pre-survey materials.

The CME Committee was instructed last year by the House of Delegates to evaluate the voluntary CME program during this year and report to the next House their recommendations for continuation of the VOLUNTARY program or the need for a MANDATORY program. Any thoughtful comments by the membership should be directed to H.H. Chun, M.D., chairman of the committee.

The House has strongly urged all physicians in Hawaii to obtain the AMA Physician's Recognition Award, or its equivalent, as documented evidence of CME, and is exerting all efforts to make requirements readily accessible. At least three of the programs below are sponsored or co-sponsored by the Hawaii Medical Association and should be of interest to all physicians.

The "Challenge of Interprofessional Communication" is planned to focus on the art of communicating to achieve positive effects of interaction between physicians, nurses, pharmacists, and other health professionals on patient care. In today's climate, it is particularly appropriate. Outstanding national experts in human behavior, patient compliance and related subjects will be here to discuss subjects of interest with all of us concerned.

CALENDAR OF ACCREDITED EVENTS—CATEGORY I

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS:

Ongoing

Kauaikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital

1. Tuesdays—CME Program, 1:00-2:00 p.m.
2. Grand Rounds, 2nd and 4th Mondays—5:00-6:00 p.m.
3. Visiting Professor Programs (see Special Events)

Kuakini Hospital

1. Hematology Conference, Monday, 8:30-9:30 a.m.
2. Gastroenterology, Tuesday, 8:30-9:30 a.m.
3. Oncology, Thursday, 8:00-9:00 a.m.
4. Endocrine, 2nd Tuesday each month, 1:00-2:00 p.m.
5. Medical Statistics, 3rd Tuesday each month, 1:00-2:00 p.m.

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

SPECIAL EVENTS:

- | | |
|-------------------|--|
| July 11-20 | Assoc. Alumni—California College of Medicine—Annual Convention, Hawaii. Write California Medical Association, 731 Market Street, San Francisco for further info. |
| July 15-August 15 | Dr. Melvin Grumbach, well-known in Pediatric Endocrinology, will be guest lecturer at Children's Hospital. Contact Sherrel Hammar, M.D., Children's Hospital. |
| Early August | Kapiolani Hospital Visiting Professor Program: M. Stenchever, M.D. of University of Utah, OB-GYN. |

- August 9-20 Eighteenth Annual Postgraduate Refresher Course presented by USC with U of H School of Medicine in Association with Tripler (Fee charged)
Honolulu (Sheraton-Waikiki Hotel)
August 9-15; Maui (Maui Surf Hotel)
August 18, 19 Kona (Kona Surf Hotel)
August 18, 19 Program is on HMA Bulletin Board
- Contact: HMA CME Office or U of H School of Medicine for further information.
- September 7 The Challenge of Interprofessional Communication by Hawaii Medical Association Program and sponsored by Lederle, Ilikai Hotel, 9 a.m.-4:30 p.m.
- September 21 "Hypertension" sponsored by Hawaii Heart Association and Hawaii Medical Association; at the Princess Kaiulani Hotel, Honolulu. For further information call Mrs. Austin, Hawaii Heart Association, phone 538-7021
- September 28 Conference on Alcoholism, "New Diagnostic and Treatment Methods," sponsored by Hawaii Psychiatric Society, APA, HMA, Department of Health, University of Hawaii. Details to follow.
Contact: Bernice Coleman, M.D.
Phone 737-7811
- September 27-October 4 Workshops in Gynecologic Oncology High Risk Pregnancy and Endocrinology-Infertility. UCSF at Maui.
Contact: Malcolm Watts, M.D.
School of Medicine
University of California
San Francisco 94143
- October 3-8 Sixth Asian Pacific Society of Cardiology Sheraton Waikiki, Honolulu
Contact: Morton Berk, M.D.
550 S. Beretania, Honolulu 96813
- November 29-December 5 American Medical Association 29th Clinical Convention Sheraton Waikiki, Honolulu
Contact: Frank A. Gray, AMA Convention Services Department
535 N. Dearborn St.
Chicago, Illinois 60610
- December 5-9 International College of Surgeons, U.S. Section Annual Meeting, Sheraton Waikiki, Honolulu
Contact: Marilyn Lento, PRC,
International College of Surgeons
1516 Lake Shore Drive
Chicago, Illinois 60610 or
HMA (CME Office)
- December 5-11 Cleveland Academy of Medicine Kona Surf/Sheraton Maui
Contact: Donald Mortimer
10525 Carnegie Avenue
Cleveland, Ohio 44106
- 1976
Feb. 15-19 Sports Medicine for Primary Physician; Lihue, Kauai; Hawaii Medical Association EMS Program

1978

April 1-7

Pan Pacific Surgical Conference, Hilton Hawaiian Village
Contact: Cesar B. deJesus, M.D.
Pan Pacific Surgical Association
236 Alexander Young Building
Honolulu, Hawaii 96813

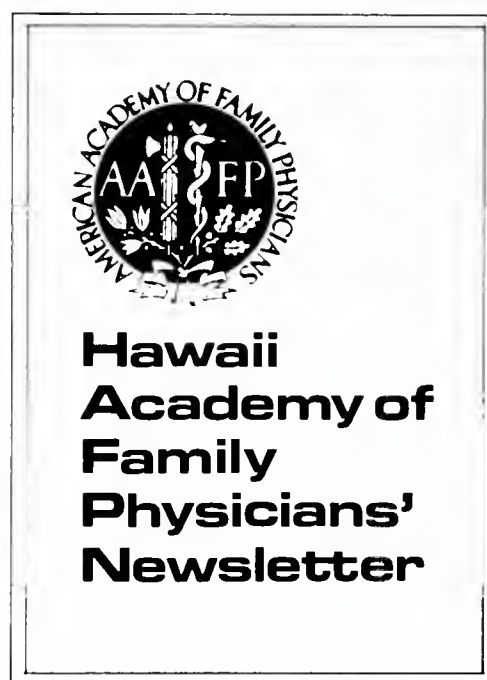
OUT OF STATE:

AMA Regional CME Programs—

8 Courses offering Category I credit

- 1) Dermatology for non-Dermatologists
 - 2) Infectious Diseases and Antibiotics
 - 3) Fluid and Electrolyte Balance
 - 4) Venereal Disease
 - 5) Pulmonary Function and Blood Gases
 - 6) Basic and Advanced Support CPR
 - 7) Basic ECG
 - 8) Human Sexuality
 - a) Minneapolis, Minnesota (July 26-27)
 - b) Williamsburg, Virginia (September 27-28)
- For further information, write:
Department of Scientific Assembly
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610

Further listings: For further detailed listings of numerous Category I accredited CME courses taking place in California and in other states, see the CME Bulletin Board at the HMA Office or refer to the JAMA, special issue on continuing medical education. Listings of weekly lectures and rounds of *not yet accredited local institutions* (Category 2 credits) will also be posted as they are received.



J. I. FREDERICK REPPUN, M.D.

NEW MEMBERS—haven't received any applications for quite a while! "Old" members are encouraged to use personal persuasive wiles to entice some of the new Family Physicians in our community to join up.

NEWS of MEMBERS—Both Felix Lafferty of the HMG and Michael Padwick of Kapaau, Hawaii have been reclassified as F-A, which means they are Fellows and Active. Congratulations. Student members of HAFP William R. Ahuna MD and Robert L. Kranz MD received their degrees in May from UHSchMed. Our other student members are in younger classes. Ahuna goes to Group Health Medical Center in Seattle for a residency in Family Practice; Kranz deserts our ranks by taking a residency in anesthesiology at the U of Texas SW Medical School Affiliated Hospitals. Good luck, lads!

ABFP—The original certification examination for the "Boards" took place in 1970, good for six years. The Board

has mailed out to those diplomats notice of the requirement to take recertification examinations in 1976—a half-day written test on 29 October plus case analyses.

CREDIT HOURS P—available in large numbers, coming up! *The 18th Annual USC-UH PG Refresher Course* comes to Honolulu 11 to 15 August. If one includes the Tripler session and the Seaside evening sessions, it is possible to garner 22.5 credit hours P. 10 hours each will be served up on Maui and in Kona. For the first time a special daily session on Family Practice has been included in the program as a result of input from HAFP and **Fred Dodge**. Unfortunately, the costs have increased to such an extent in putting on these programs, that Hawaii physicians' registration fee will be \$200 for all or any portion of the program. The regular fee is \$235. It will be especially expensive for physicians on the Big Island and on Maui who wish to take only the 10 hours offered on each island. There will be no reduction for just the early morning sessions.

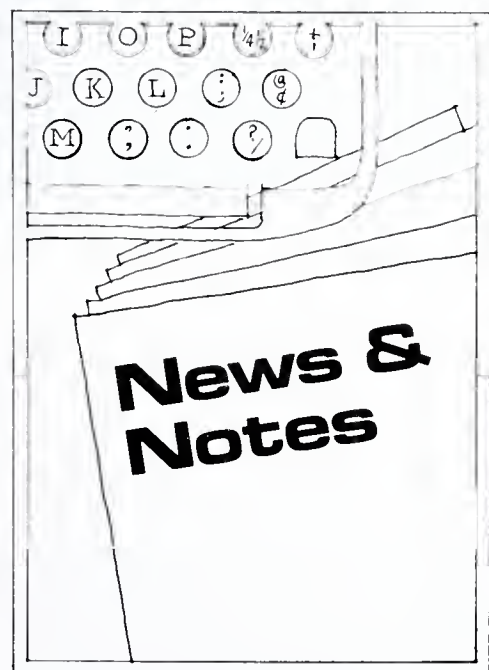
In 1976, February 15 to 19, *Sports Medicine for the Primary Physician*, offering 20 hours of P credit, sponsored by UHSchMed and HAFP, will be held on Kauai. For details, write or call **Richard H. Strauss MD**, Dept of Physiology, Biomed Science Bldg, 1960 East-West Road, Honolulu 96822.

Core Content Review 1975-1976—again offers 18 hours of credit P. The deadline to sign up for this correspondence self-evaluation and learning experience is 31 August. The first 100-question pamphlet will arrive on 1 October. If you have not already received a mailing on this, write Core Content Review, 4075 N. High Street, Columbus, Ohio 43214. The price is a reasonable \$40 for AAFP members and \$60 for others.

Anyone interested in combining Mardi Gras with a "Supercourse" in respiratory care and pulmonary function offering some 30 hours of P credit? *American Thoracic Society of Louisiana*—the week of 16 February 1976, preceding New Orleans' carnival season. \$150 and contact ATSL, Suite 1504, 333 St. Charles Ave, New Orleans LA 70130.

If you'd like to go to New Orleans earlier, 3 to 6 November 1975 Interstate PG Medical Ass'n offers 20 hours of P credit for a \$40 fee if paid in advance; the program is designed for primary care physicians. Box 1109 Madison Wis 53701.

Les Vasconcellos—members will be happy to learn that Les was seen up and about, looking great, at the HCMS meeting addressed by Senator Dan Inouye.



HENRY N. YOKOYAMA, M.D.

Life in These Parts

Something's always happening in Kona... Now ten Kona doctors have decided to quit attending strangers at the State

run Kona Hospital emergency room unless the State provides some form of protection against malpractice suits... Their action was prompted by a string of malpractice suits by tourists, capped by a more recent suit for \$5 million... We don't blame them...

Retired Queen's radiologist "**Tad**" J.C. Wang was about to go to Niger, Africa a year ago but had to suspend his missionary zeal because of an untimely revolution in that country. Tad is now chief medical officer of the Kalihi-Palama Walk-In Clinic at Kaumakapili Church and is one of the driving forces behind the clinic. Besides Tad, eleven volunteer doctors squeeze in time at the clinic between their own schedules. The volunteers include general practitioners, a cardiologist, an ophthalmologist, a clinical psychologist, an OB man, an ENT man, a pediatrics team from Children's Hospital and of all specialists, a nuclear medicine man?

When an 86-year-old man fainted during a public meeting at Kula Elementary School on Maui, the two physicians registered among the audience of 130 did not volunteer their services for fear of malpractice suits. Later, one of the doctors in the audience who is 70 and retired from active practice explained, "The first doctor to touch that man would be liable... I'm not carrying malpractice insurance now..." (Maui is where internist **Jack Morris** helped a man in a bar who had fallen off a bar stool and got sued...)

Our two-week-old hair transplant plugs were beginning to scab and dot our thin scalp. The oriental patients are generally quite polite and careful not to offend. They would cast surreptitious glances but kept their curiosity to themselves... That is, all except one outspoken elderly lady who asked, "Doctor, are you getting moxa treatments for your headaches?"

At HMA meetings, the instant tea and coffee come in unmarked jars. Even after all these years, we still keep forgetting whether it was the coffee or tea that comes as coarser granules... We mentioned our predicament to pathologist **Ann Catts** one day at a meeting. She suggested, "Why don't you sniff at them?" When we wondered about the aesthetic objection to our sticking our nose into those jars, Ann was quite dogmatic: "We sniff at our culture tubes..."

Hawaii Heart Association president **James Orbison** reported that 2,823 residents of Oahu, Hawaii and Kauai had their blood pressures checked during Hawaii High Blood Pressure Month (May) and 177 or 6.7% had elevated readings. Jim estimates that 85,000 Hawaii residents have hypertension and half of them don't even know it.

Hawaii is one of 30 centers participating in the National Heart and Lung Institute's \$16 million, three year study known as ANHS (Aspirin Myocardial Infarction Study). Judson McNamara is principal investigator with co-investigators Samuel Gresham and Alfred Morris. The project is recruiting 150 volunteer Oahu men and women aged 30 to 69 who have had at least one documented heart attack in the last 5 years.

It was one of those hectic Saturday mornings and the 4 bottles of sake we had consumed the night before at the Japanese Speakers Bureau meeting did not help. Our nurse summoned us to the phone, handed us a patient's chart with the message that Dr Sakamaki wanted to discuss the patient. We surmised that **Ken Sakamaki**, our skin diving dentist friend was inquiring about the patient's diabetic condition and whether she could safely have a dental extraction. "Hey, how's the great skin diver doing these days?" There was an odd silence, then, "This is Leigh... Mrs _____ is getting a funny reaction to your Desbutal... I wonder if I can switch her to Sanorex?" (Funny, we thought... Dentists must get samples of diet pills these days and since they have started checking blood pressures, they are now prescribing diets as well...) "Well, you know she's also depressed and the reason I gave her Desbutal is that I find it a good antidepressant as well... Go ahead and give her a few samples, but she'll react to anything we start... She's also on Triavil from her psychiatrist..." With this we hung the phone... (That's odd? Did he say he was Leigh? Hey, I wasn't talking to Ken Sakamaki... Why am I telling **Leigh Sakamaki**, her psychiatrist what to prescribe...)

LIFE AFTER DEATH.

Mr. R. L., 50, has only 10% of his sight. Mrs. J. D., 39, spends three days a week attached to an artificial kidney. Billy, 6, suffers from a serious blood deficiency.

Hundreds of persons in Hawaii are cursed with blindness, kidney diseases and bone marrow disorders.

Some can be helped, others cured completely, through medical transplants.

We have the technology. We have the patients. All we need are the donors. And that's the task of Makana Foundation — Hawaii's own organ and tissue registry.

By filling out a simple form, you can bequeath your vital organs at time of death. You won't be needing them. Someone else will.

In a secular way, you will be giving life . . . after death. It is the ultimate makana.

For a donor card and a brochure, write Makana Foundation, Post Office Box 3739, Honolulu, Hawaii 96812. Or phone 536-7416. After hours 536-7771.

MAKANA FOUNDATION

Bulletins

Dave Ferguson reports that the Sept 21st Symposium on Hypertension at Princess Kaiulani will feature two outstanding experts in the field viz **Ronald Okun**, chief of the Mount Sinai Hospital Dept of Clinical Pharmacology and **Edward Biglieri**, Professor of Medicine at U.C. San Francisco. The Symposium is geared to the practicing physician and should improve his understanding and treatment of hypertension. The Symposium (Category 1 credit) is sponsored by the Hawaii Heart Association and the H.M.A. and supported by Searle and Ciba.

The Hawaii Society of Pathologists will hold their slide seminar on July 25, 26, and 27 at the Maunakea Beach Hotel. Those interested are to contact **James Navin**.

Tom Thorson's Corner

A black boy polishing a brass railing tarnished by small black specks in an old Atlanta hotel mumbles to himself, "There never was and there never will be . . . There never was and there never will be . . ." An interested guest asks, "Son, what never was and never will be?" Came the reply, "A constipated fly."

Two locals decided to form a new bank with the slogan, "The Bank that Says Huh!"

Instead of "See Your Doctor!" the current slogan is "Sue Your Doctor!"

Sportsmen

We received a call from **Tom Frissel** to come pick up fish and what fish they were . . . A 30-lb Ono and a good sized Aku . . . Tom had just returned from his annual 4-day July 4th weekend fishing trip off Niihau with **Ted Tseu** and **Roy Kaye**. Ted was the big fisherman catching a 40-lb Mahimahi and a 30-lb Uku on spinning gear. "I was the big eel catcher" Tom sez, having landed two large eels while bottom fishing . . . The group netted 7 Mahimahi, 2 Ukus, 1 Ono, several Uluas and plenty of Aku and Mempoichi to conclude a pleasant and fruitful trip . . .

One Wednesday afternoon in June, **Clifford Chang** was playing in a foursome with **Calvin Kam** and **Allan Young**. On the 15th tee, at Mid Pac CC, he duck-hooked his tee shot. The errant ball headed for the open door of the john and landed kerplunk in the toilet bowl. Realizing this was an unplayable lie, Cliff had no recourse but to — on his recalcitrant ball and flush it down . . .

In June, Kaiser physician **Bill Harris** set a new hang gliding world record by flying 28 miles from Makapuu to Hauula, breaking the old mark of 25 miles set in California. Cyclist **Dale Adams** a pre-race favorite, broke his clavicle in a four-bike crash in the first lap of the 110 mile Senior Division Hawaii State Bicycle Championships on June 29 . . .

Elected, Appointed & Honored

Ronald Pion Med School Professor of Ob Gyn and of population studies and family planning won the annual Sippy-Dorsey award of the Western Branch of the Public Health Association for his work in community public health education and patient education. **George Starbuck**, medical director of the Children's Protective Services Center at Children's Hospital was named physician alumnus of the year by the University of Vermont medical school alumni for his "many years of exemplary medical practice and outstanding community service which reflects credit upon the medical profession and epitomizes the ideal physician." Hilo physician **Ben Ill-Moo Hur** was named the third County Physician for

continued page 260

EclipseTM Sunscreen provides up to six hours of protection, even after swimming.



10:00 A.M.

Eclipse is protecting.



1:00 P.M.

Eclipse is still protecting.



4:00 P.M.

Eclipse is still protecting.

Eclipse protects so long because it utilizes the moisturizing Aquacare[®] base. This means Eclipse is resistant to wash-off and protects against the dryness associated with exposure to wind, water and sun.

In a study to determine just how various sunscreens could be counted on to protect your patients, Eclipse was compared to PreSun[®], Uval[®] and Solbar[®]. Approximately 30 minutes before exposure, equal premeasured doses of the sunscreens were applied under double-blind conditions to 3 inch squares demarcated with tape on the patient's back. The group was then exposed to 6 hours of sunlight interrupted by two 15 minute swimming periods. Evaluation of the resulting erythema was made at 0, 24, and 48 hours following the end of exposure and ratings were assigned to each test site*. Analysis of the results of this study indicate that Eclipse is clinically superior to the other formulas tested following 6 hours of continuous sun exposure.

Results (averages & ranges) can be seen in the Table at right. This study was conducted by Robert Kim, M.D., Straub Clinic and Hospital, Honolulu, Hawaii¹

¹G S Herbert Laboratories technical report #9



	ECLIPSE	PRESUN	SOLBAR	UVAL
Average ratings immediately after exposure	0.66 (0.80-1.00)	1.17 (1.00-1.30)	1.60 (1.00-2.00)	1.23 (0.60-1.80)
Average ratings 24 hours after exposure	1.13 (0.80-1.80)	2.66 (2.00-3.00)	2.76 (2.50-3.00)	2.66 (2.50-3.00)
Average ratings 48 hours after exposure	1.00 (0.50-1.80)	2.43 (2.20-2.70)	2.66 (2.50-3.00)	2.76 (2.70-2.80)

*The rating scale used for the study is as follows
0=No Erythema □ 1=Mild Erythema
2=Moderate Erythema □ 3=Marked Erythema
4=Marked Erythema with Edema

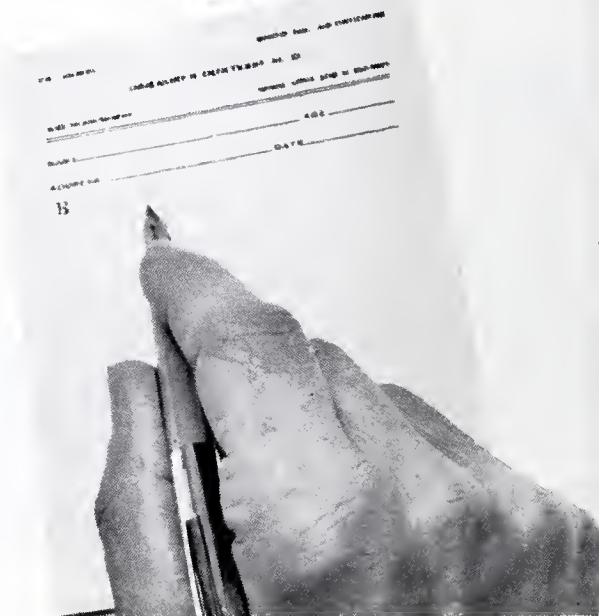
Ranges appear in parenthesis

Eclipse Sunscreen Lotion
3% amyl dimethyl PABA and
3% glyceryl PABA in the
moisturizing Aquacare base

G. S. Herbert Laboratories
Irvine, California 92664 U.S.A.



Bioequivalence



the weight of scientific opinion:

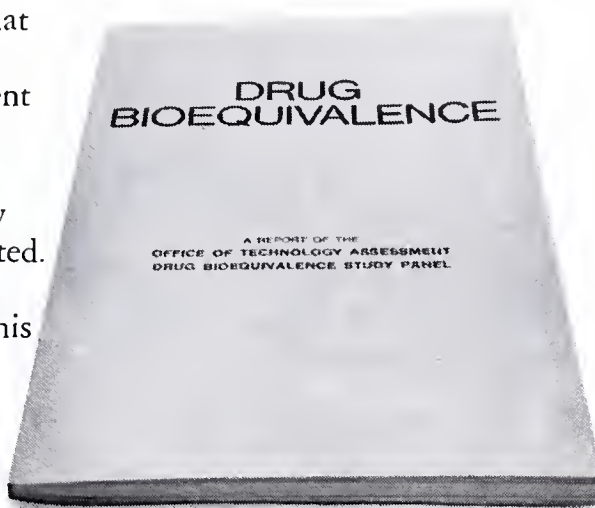
If the pharmacist substituted a chemically equivalent drug for the one you have specified for your patient—could you be certain of that product's safety and effectiveness simply because the chemical content was the same?

Definitely not, unless bioequivalence tests and other quality assurance checks had been conducted. The pharmaceutical industry and many scientists have maintained this position for years, but others have questioned it. Now the Office of Technology Assessment of the Congress of the United States has reported on the issue in its Drug Bioequivalence Study.*

Here are a few definitive statements in the O.T.A. report:

"...the problem of bioinequivalence in chemically equivalent products is a real one. Since the studies in which lack of bioequivalence was demonstrated involved marketed products that met current compendial standards, these documented instances constitute unequivocal evidence that neither the present standards for testing the finished product nor the specifications for materials, manufacturing process, and controls are adequate to ensure

that ostensibly equivalent drug products are, in fact, equivalent in bioavailability.



"While these therapeutic failures resulting from problems of bioavailability were recognized and well documented, it is entirely possible that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

The Pharmaceutical Manufacturers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical products, subject to new drug procedures, to document:

(a) chemical equivalence; and

(b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or (c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual inspections and certification thereafter, and strict adherence to FDA regulations on good manufacturing practices.

The overall quality of the United States drug supply is excellent. But only a total quality assurance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription...




Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

protecting the integrity of your prescription

2 tablets B.I.D. check



Unchecked
E. coli reach exponential growth rates when bladder defenses are weak. Gantanol® (sulfamethoxazole) can usually check the growth of *E. coli* in 48-72 hours and sterile urine should be achieved within this time frame in uncomplicated cystitis due to susceptible strains of *E. coli*.

exploding counts of E. coli

For acute cystitis*

Gantanol B.I.D.[®] sulfamethoxazole/Roche[®]

Basic therapy with convenience:

4 tablets (0.5 Gm each) STAT — then 2 tablets B.I.D.
for 10 to 14 days

*Nonobstructed; due to susceptible strains of *E. coli*

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms.
Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm b.i.d. or t.i.d. depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs b.i.d. Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.



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Hawaii County to complete the three member County Physician team which includes **Pete Okumoto** of Hilo and **James Mitchell** of Kona...

Miscellany

Surgeon complimenting his OR nurse after the surgery: "You were a big help... But please don't say 'Oops!' when the patient has only had local anesthesia..." (**Betty Anderson**)

The doctor had ordered a 24 hour urine specimen. As the nurse handed her the specimen bottle, the shy old lady had a quizzical look but said nothing... Around midnite, there was a frantic telephone call: "Doc, its only been 12 hours, but I can't hold it any longer..." (**Dick Dennis**, our tennis playing architect friend)

A young man complaining of chronic fatigue had a thorough physical and all lab tests were normal... The doctor recommended, "The best thing for you is to give up drinking and smoking, go to bed early and stay away from women..." The patient pleaded, "What's next best, Doc?" (**Tom Thorson**)

Professional Moves

Homo Sapiens Medicus, apparently not in a migratory mood, is certainly not stirring much... In June, **Bill Walsh** announced that he was resuming his practice at 363 Alexander Young Building and internist **Ernesto Orinon** relocated to the Kailua Square Building, Kailua. Psychiatrist **Guy Spinello** joined the Human Resources Development Center, Inc at 1110 University Ave and **Erlinda Cachola** discontinued her practice at The Kalihi Branch Office of the Waianae Medical Clinic Inc. On Maui, two GP's, a **Rolland Erickson** from Minneapolis, Minnesota and a (?) **Bird** from San Francisco, Calif took over **J. Alfred Burden's** practice.

Miscellany

What happens if you mix the two movies, "Earthquake" and "The Towering Inferno"? Naturally you'd get "Shake and Bake." (**Sharon Bindliff**)

Have you heard about the new illegitimate cereal on the market? "Snap, Crackle, but *no* Pop!" (**Sharon Bindliff**)

Man or Animal?

Our scholarly editor **Harry Arnold Jr** has been campaigning for years for the use of "Man" and "Woman" instead of "Male" and "Female" to mean the human male and female species. He attended a medical meeting where the protocol

described "a 4½-year-old white male with..." and the patient presented was a 4½-year-old male white poodle. Harry threatens to introduce a brown male dog at a medical meeting as a "colored male..."

Conference Notes

Benjamin Gordon, director of KMRI feels that "Hawaiian Asthma" is an entity just as "New Orleans Asthma" and "Philadelphia Asthma." Ben says "Hawaiian Asthma" is characterized by the following: It is an unusually severe asthma... It is the only real multiethnic asthma in a tropical setting... Hawaii has the dubious honor of having the highest asthma prevalence rate in the U.S. and the highest mortality rate (2 times the national average)... It is one of the 2 commonest causes of chronic illness in Hawaii... It has the youngest mean age of morbidity and mortality... Approximately 70% of pollen collected are of the same species—a "Pollen X" which is as yet unidentifiable... The local atopic rate is 10 to 40% and genetic factors are involved ie, IgE levels are higher in atopics... Contrary to common belief, the highest incidence in Honolulu is in the dry Kaimuki and Diamond Head areas, not wet Manoa... And there is no significant correlation with Kona weather... All therapeutic modalities work less well in Hawaii than elsewhere...

Oncology Dialogue

A 66 year old Japanese man had a 3-4 cm left breast lump for 6 months which became more tender the past month... Xerography was suggestive of CA. He had a modified radical when the frozen was adenocarcinoma. Pathologist **Grant Stemmerman** reported: "This is our first case of male breast carcinoma. The male-female ratio is 1:100 in most countries... Any country with a low risk female breast cancer has a low risk male breast cancer. The prognosis is the same for men and women, but the mortality is greater in men because the men are usually older." Radiotherapist **Ed Quinlan** added: "If it is a central lesion, 30-35% have internal mammary tastasis. So radiation therapy is indicated in central lesions." Fellow radiotherapist **Carl Boyer** commented: "We've had 2 cases at Queen's, both were central lesions." Stemmy asked, "Did we get a bone scan?" Carl: "That would be a good preop procedure." Stemmy: "Good post op too. Any children? There is an increased incidence of male breast CA's with Klinefelters... Is **Francis Oda** here? He is one of the co-authors in the treatment of mammary CA's with hormones."

A 75-year-old Japanese woman was found to have an undifferentiated adenoCA of the sigmoid colon with pericolic extension and secondary abscess formation. Two years earlier, she had a villous adenoma of the rectum excised and for the past 3-4 months had complained of rectal heaviness and

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AUGUST, 1975
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Hawaii Medical Journal

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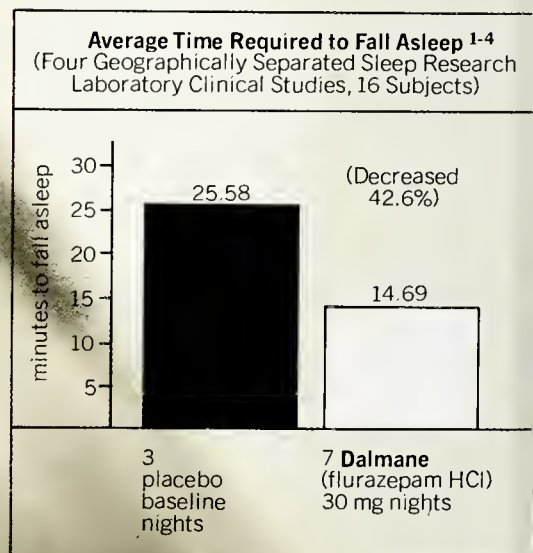
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REFERENCES:

1. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
2. Frost JD Jr: A system for automatically analyzing sleep. Scientific exhibit at the 24th annual Clinical Convention of the American Medical Association, Boston, Nov 29-Dec 2, 1970; and at the 42nd annual scientific meeting of the Aerospace Medical Association, Houston, Apr 26-29, 1971
3. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
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Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly

or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

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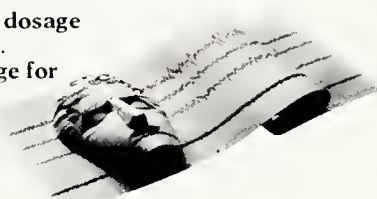
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SUNSHINE '75: ROCK MEDICINE INSIDE DIAMOND HEAD

PATRICIA A. SEXTON, B.A.*, R. STANLEY BURNS, M.D.** and
STEVEN E. LERNER, M.S.***

● *Sunshine '75, held January 1, 1975 is representative of a type of "rock" music event which occurs frequently in the United States. These rock music concerts are daytime events, with large numbers of young people congregating for periods up to 24 hours. They gather in an open-air urban setting such as an arena or stadium, to hear the music of a featured rock group, from which the event gains its identity. Drug-taking is frequent and appears to be a socially accepted behavior at such events.*

A small medical literature, dating to 1973, describes the medical needs and provision of medical care at six rock music concerts which took place between July, 1972, and July, 1974. Four of these concerts were held in stadia in the San Francisco Bay Area, one in Washington, D.C., and the sixth in Honolulu. The crowd size ranged from 20,000 to more than 50,000, with people in attendance for eight to 12 hours.

People who were provided with medical care varied from 1/3 to 2/3 of one percent, or one per 150 to 300 attending. Eight to 45 percent of those treated presented with a problem considered to be drug-related in nature.

These articles discuss and provide guidelines for organization of medical care delivery, and the medical supply and general staffing requirements. Drug-related medical problems are discussed with emphasis on the need for medical team members with specialty training and experience in the drug abuse field. Several factors which seem to play an important role in determining the medical needs of this type of rock music event have been defined by these au-

thors. They include the number of people in attendance, the length of the event, the geographical location, the weather, the type of music played and, in particular, the featured group; the types and quantity of drugs taken, the "collective mood", and the acceptance of the medical staff and facilities by the crowd.

Sunshine '75 is unique with its natural stadium setting. Like other crater concerts, it gained identity primarily from the setting and not the musical groups performing. The Sunshine Festival is an annual event with a past and a future. Lessons learned in the provision of medical care at one concert can be directly applied to the planning for subsequent concerts.

The Waikiki Drug Clinic (WDC) has provided emergency medical services for the crater concerts since June, 1970. Reflecting a general trend, the provision of medical care at crater concerts has become the domain of special "rock medicine teams" which are built around health professionals with experience and training in the fields of emergency medicine and drug abuse. The WDC staff now works closely with the concert staff prior to each event, and the rock medicine team has become an integral part of rock music events.

The Seventh Annual Sunshine Festival was held in Diamond Head crater on January 1, 1975. There were approximately 35,000 people in attendance for a period of 10 to 12 hours.

This paper describes the medical needs and medical care delivery at Sunshine '75, and compares this with the experience at the Komo Mai Diamond Head (July 4, 1974) crater concert. The classification of medical problems as drug-related will be discussed. It is recommended that drug-taking patterns observed at rock concerts be used as a barometer by the medical community in predicting future trends in drug-related medical problems.

*Program Director, Waikiki Drug Clinic.

**Clinical Investigator, San Francisco Polydrug Project and Research Associate (Rock Medicine Team) Haight-Ashbury Free Medical Clinic.

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Accepted for publication March, 1975.

TABLE 1.—Staff Schedule

TIME	PHYSICIANS	NURSES	COUNSELORS	FIELD MONITORS
6-9 a.m.	1	3	5	3
9-12 noon	1	3	5	3
12-3 p.m.	3	3	6	3
3-6 p.m.	2	3	5	3

Medical Staff and Coverage

The medical staff at the concert numbered 40 and was composed of five physicians, four nurses, four ambulance attendants, and volunteer counselors from the WDC. All personnel working on the team were required to have completed cardiopulmonary resuscitation training.

It was expected that people attending the concert would be present in the crater for 12 hours, from 6 a.m. until 6 p.m. Four shifts were defined and personnel were assigned to one of three elements of the medical care delivery system: the field monitoring team, an auxiliary aid station or the main medical tent (See Table 1).

Medical Care Delivery

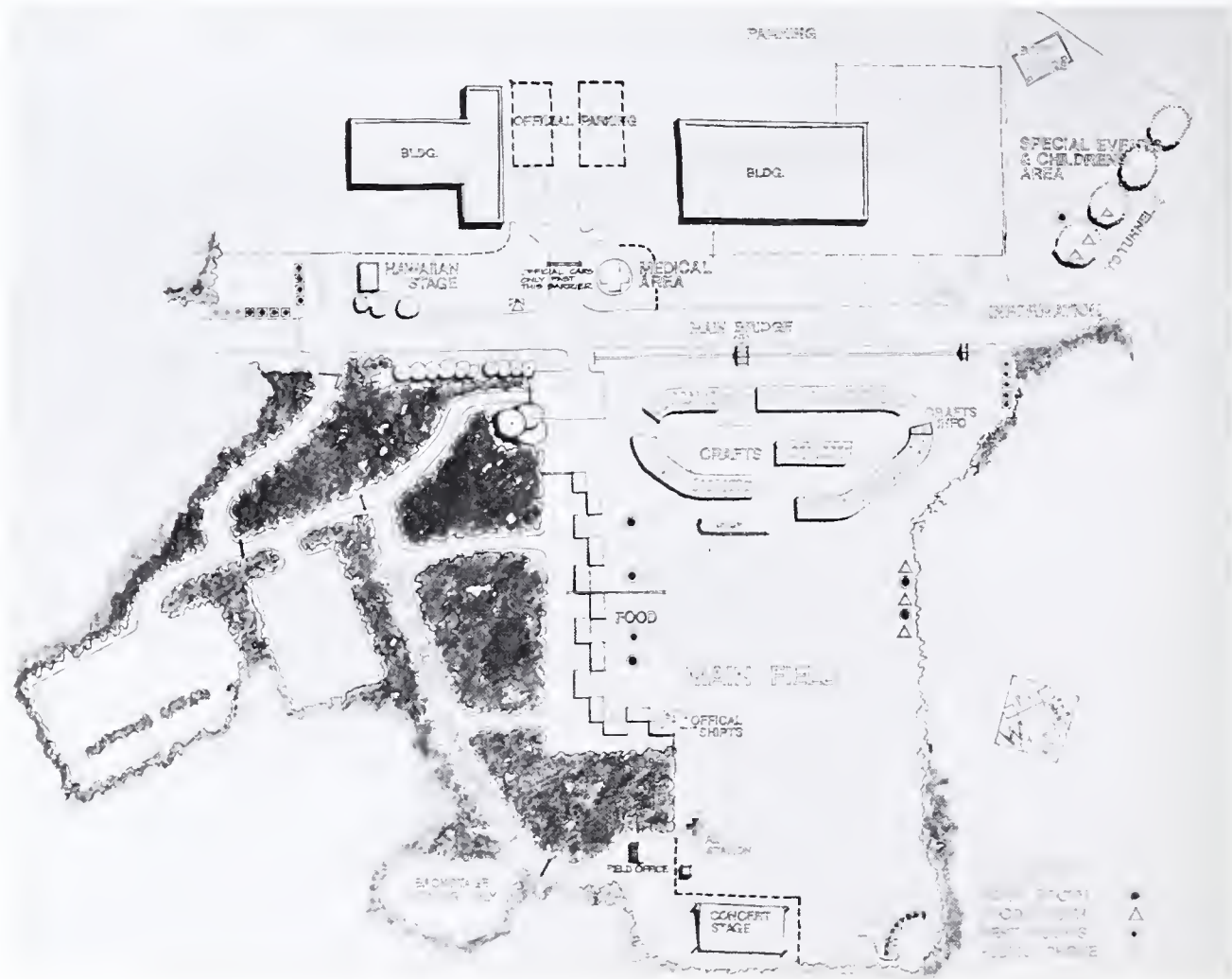
The actual land area within the crater totals approximately 125 acres, with 20-25 acres being used as the concert site (See Figure 1). The

field monitoring teams were assigned to one of three designated areas of the field. Each team was equipped with a walkie-talkie and an emergency kit for the provision of minor first-aid procedures. Thier task was to monitor the crowd, summoning assistance in an emergency; to direct people to the medical tent; and to suggest preventive measures.

The auxiliary medical aid station was located to the right of the main stage, next to the concert office. The aid station was staffed by counselors from the Clinic, with a nurse present from 9 a.m. to 6 p.m. This station served as a referral point to the main medical tent and provided first aid for minor trauma.

The main medical tent was located to the rear of the cleared area (See Figure 1), under a large shade tree with easy access to one of the two exits leading from the crater. This site has been used for all of the concerts, and is designated by a large red cross flag 20 feet in the air. For

FIG. 1—Layout of Sunshine '75 Rock Music Concert



those unfamiliar with the medical services provided, announcements of the location of the tent were made hourly from the main stage, with assurance given that the staff was there to help them.

Emergency Vehicles and Medical Back-up

Two fully-equipped ambulances and four attendants, provided by Pacific Ambulance were present at the medical tent during the entire concert. Communication was maintained with the aid station via a field radio and with the field monitors by walkie-talkie. A cleared access road which ran along the main field was to be used for the transportation of serious cases from the aid station.

The City and County ambulance service was the potential need to transfer patients to local contacted prior to the concert and informed of the potential need to transfer patients to local hospital emergency rooms. They were given instructions on entry into the crater and the location of the medical tent.

Hospital emergency rooms were contacted by the Clinic staff one day before the event.

Spectrum of Cases Seen

Of the persons attending the concert, 134 presented for medical care. The majority of the patients were female (52%), and their median age was 19.

Cases were separated into 'minor' and 'major' on the basis of requirements for management and treatment. The subdivision of cases into 'drug use present' and 'no drug use present' refers to whether drug use was part of the presenting picture by history or on physical examination.

Minor Problems

Of the presentations for medical care, 129 (96%) involved minor medical problems and minor trauma (See Table 2).

TABLE 2.—Minor Problems Seen at Sunshine '75 Rock Music Concert

NO DRUG USE PRESENT		NUMBER
Environmental stress		
sun exposure		4
temperature related problems (heat exhaustion)		2
Minor medical problems		
headache		38
G.I. complaints		10
menstruation (napkins, cramps-2)		9
insect bites		3
toothache		2
care of infected, old injury		1
other (asthmatic attack)		1
Minor trauma		
lacerations		
superficial		21
required suturing		1
friction blisters		11
removal of foreign body (eyes-2)		6
burns (firecrackers-3, flare)		4
abrasions		3
dressing old injuries (lacerations, skin graft)		3
musculoskeletal injury (sprain ankle)		1
other (abscess, epistaxis, loss of toe nail)		3
DRUG USE PRESENT		
Agent(s)	Presenting Picture	
alcohol	minor medical problem (light-headedness, inability to walk)	2
	minor trauma (laceration)	1
marijuana	minor medical problem (headache)	2
	minor trauma (burn-firecracker)	1
alcohol and marijuana	minor medical problem (sunburn, heat exhaustion, "intoxicated")	3

No drug use was noted in 120 cases (90%). In the nine cases where drug use was part of the presenting picture, the chief complaints were similar to the cases where no drug use was present.

Major Problems

Five cases were considered to be major medical problems, with no cases of major trauma represented. (Table 3) In four cases, drug use was part of the presenting picture.

TABLE 3.—Major Problems Seen at Sunshine '75 Rock Music Concert

CASE NUMBER	PRESENTATION	MANAGEMENT/DISPOSITION
NO DRUG USE PRESENT		
1	Major medical problem: 25-year-old male, fever (103°F), nausea & vomiting; 24 hour old second degree burn of leg. Rule out: superimposed infection/septicemia	Vital signs, Tigan, Tylenol, refused re-dressing of burned area, released to home.
DRUG USE PRESENT Agent(s)		
2	LSD Major medical problem: 30-year-old male, LSD taken day before concert, no sleep past 72 hours, "tired, cold exhausted," abdominal cramps, muscle spasm.	Vital signs & observation—1 1/2 hours, Bentyt, hot pack & massage to legs, released to home.
3	MDA & alcohol Major medical problem: 20-year-old male, "drowsy", bloody vomitus, drinking beer & "snorted" 1/2 hour prior to arrival at tent.	Vital signs q 15-30 minutes & observation—3 hours, left AMA at insistence of friends.
4	PCP Major medical problem: 23-year-old male, "passed out" on the field, brought in by stretcher.	Vital signs q 15 minutes & observation—1-1/2 hours, released to home.
5	PCP & marijuana Major medical problem: 15-year-old female, "overdose", "smoked a marijuana joint laced with something" (per friends)	Vital signs q 15 minutes & observations—1 hour, 'talk down' technique, released to home.

Case 2, with a history of ingestion of LSD the day prior to the concert, reflects a general phenomenon where people in attendance were still recovering from the "celebration" of New Year's Eve.

The hematemesis which followed the ingestion of alcohol and MDA (3, 4-methylenedioxy-amphetamine) in case 3 cannot be considered a direct, acute toxic effect of MDA.

Cases 4 and 5, involving the use of PCP (phencyclidine), reflect the general trend of increasingly more frequent and widespread use of this psychedelic drug throughout the United States.

No cases were transferred to hospitals.

Figure 2 shows the case load by the hour.

Discussion

Of more than 35,000 people in attendance at Sunshine '75, 0.38% received medical treatment, representing approximately one out of every 300 persons. This is similar to the experience at the Komo Mai Diamond Head, July 4, 1974 crater concert (0.34%),¹ and compares favorably with the reported experience at other rock music concerts of this type.

Drug use was present in 10% of the cases seen at Sunshine '75, and 14% of the cases seen at the Komo Mai Diamond Head concert. However, only 7% and 8%, respectively, of the medical problems were considered to be directly related to recent drug use. These latter figures are lower than other reported rates of drug-related medical problems (21 to 45%), and may reflect a lower

rate of drug use and a different system of classifying medical problems with reference to drug use.

Not all cases where drug use is present represent medical problems which can be directly related to recent drug use, nor should they be considered of 'major' proportion. One must consider that people who use 'familiar' drugs at rock concerts seem to function reasonably well in this setting, but are susceptible to the same trauma and illnesses as those who do not use drugs.

In contrast to the 27 cases of sun exposure and heat exhaustion seen at the Komo Mai Diamond Head concert (mean daytime temperature 83°F, clear), only six cases at Sunshine '75 (mean daytime temperature 76°F, partially cloudy with some rain) could be considered in this category. This highlights the effects of temperature and sun on a crowd of people in an area with limited shade and shelter.

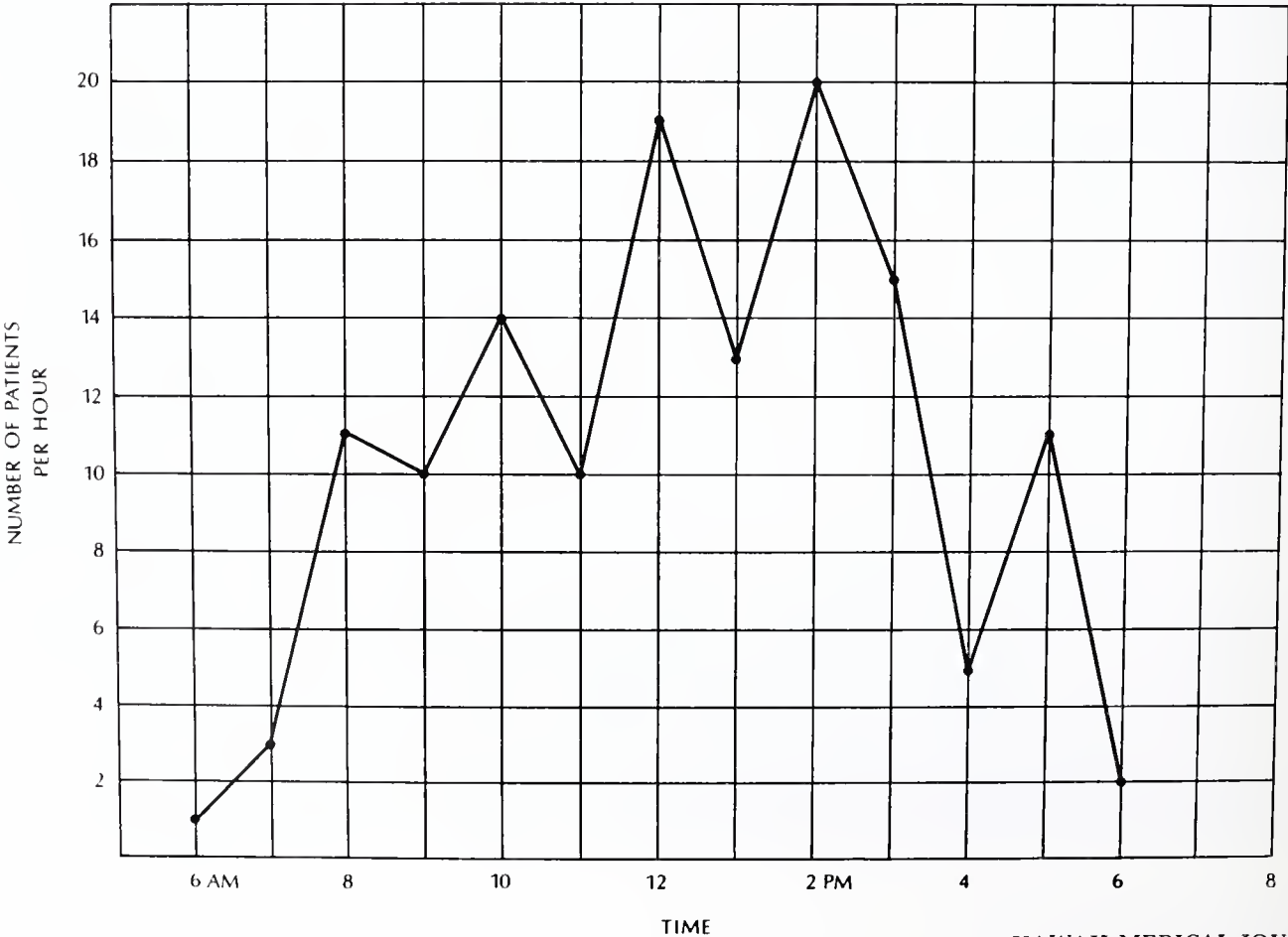
Superficial lacerations of the hands and feet resulting from the sharp edges of cans have continued to be a problem. A few individuals sustained lacerations of the feet from broken glass on the grounds.

The appearance of firecrackers inevitably is associated with cases of minor burns.

Three of the 10 divers in the precision sky-diving group, Para-Descenders, missed the crater and landed on Diamond Head's slopes. An ambulance was dispatched to the landing site of one diver, but no injury had been sustained.

The body of an 18-year-old youth was found outside the crater in a ravine near the base of

FIG. 2—Case load by hour



the crater's ewa side. He had apparently attended the concert and fell as he was walking along the rim. The rock medicine team was not involved in the discovery or rescue operations outside the crater.

The Waikiki Drug Clinic was progressive in the development of emergency medical services for rock music events. Drug usage patterns at rock music concerts are documented by the collection of 'street drug' samples for analysis and the recording of recent drug-use history in those persons attending the concert who received medical care. Two relatively uncommon psychedelic drugs, MDA and PCP, surfaced at Sunshine '75; this may herald the appearance of future management problems for health professionals related to these agents.

Robbie Corrado, R.N., Director of Rock Medicine Section, Haight-Ashbury Free Medical Clinic, has indicated that drug usage patterns observed at rock music events have been one of

the best predictors of what the medical community will face in the near future with respect to drug-related medical problems.

Patterns of drug-taking associated with rock music events offer one of the few, large scale, cross-sectional views of evolving drug use trends. It is important that these patterns be documented and reported to the medical community.

Acknowledgments

We are indebted to Jay Anderson and Tom Hackett of Anderson and Reinhardt, Ltd., for graphics; the Staff of Sunshine Festival, Inc., and in particular Ken Rosene for their assistance, and to the Staff and volunteers of the Waikiki Drug Clinic; without their assistance, the services would have not been delivered.

Address requests for consultation services or reprints to: S. Lerner, 527 Irving Street, San Francisco, CA 94122

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Madness in Paradise: Psychiatric Crises Among Newcomers in Honolulu

STEVEN P. KIMURA, M.S.W., PATRICIA L. MIKOLASHEK, M.S.W., and
STUART A. KIRK, D.S.W.*, *Lexington, Ky.*

The advent of commercial, long distance, rapid air travel and the emergence of masses of people from industrialized countries with both the financial resources and the leisure time to use such transportation, have permitted more people to travel more often and to farther destinations than ever before. Moreover, this trend will undoubtedly continue and accelerate. Des-

pite the magnitude of the phenomenon, little is known about the psychiatric problems people have in rapidly adjusting to new social and physical environments during extended and distant travel, or the way in which travel may be used by those experiencing psychiatric difficulties.

Although travelers pass through virtually every city in the world, some cities have a much higher concentration of tourists and provide a

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TABLE 1.—*Age Distribution in Four Studies*

AGE	NORMAL WESTBOUND TRAVELERS ¹²	NORMAL JAPANESE BASED TRAVELERS ¹¹	ALL E.R. PSYCHIATRIC PATIENTS ¹⁰	NEWCOMER E.R. PSYCHIATRIC PATIENTS
10-19	6.4%	1.9%	9.7%	6.7%
20-29	16.7	38.9	37.0	40.0
30-39	14.2	24.4	17.7	16.7
40-49	21.7	18.1	17.0	13.3
50-59	23.0	10.0	10.0	8.3
60-over	15.4	6.7	7.3	1.7
Missing data	<u>2.6</u>	<u>—</u>	<u>1.3</u>	<u>13.3</u>
Total	100.0	100.0	100.0	100.0
N	(1,424,591)	(270)	(310)	(60)

more fertile site for an exploratory study into the psychiatric crises of travelers. Honolulu, Hawaii, is one such location, and informal reports from psychiatric agencies there initially indicated that a sizable number of vacationers in Honolulu do find themselves in need of emergency psychiatric services in local hospitals and clinics. This apparent paradox of personal crisis during a trip to a vacation paradise constitutes the major focus of this study.

A review of the major medical, psychiatric, psychological and sociological journals and abstracts uncovered no references to research on the subject of psychiatric crises among travelers. There is, of course, a sizable literature on geographic mobility (immigration and migration) and mental illness,¹⁻⁴ although the findings are inconclusive and deal with birthplace and place of present residence, rather than with the immediate consequences of relocation or travel. Similarly, research on psychiatric disorders among residents of "new towns" in England⁵, and on the psychiatric help-seeking of recent (within five years) arrivals to Los Angeles⁶, fails to focus on the immediate or short-term effects of the departure, travel, and arrival phases of migration, in which stress may be greatest.

Findings

DEMOGRAPHIC CHARACTERISTICS

Half of the newcomers (46.7%) who came to the emergency room for psychiatric help were

under 29 years old (see Table 1). This is the same proportion as the "normal" psychiatric patient (46.7%), but considerably younger than the typical tourist to Hawaii, particularly tourists who were "westbound," i.e., from the U.S. mainland (23.1%). Over half of the newcomer sample (55%) is male, which is only slightly greater than the percent of males in the psychiatric emergency population (47%), and similar to Japanese (56.8%), but not mainland visitors (44.5%), as shown in Table 1. The greatest percentage of the newcomer sample (35%) came from the Pacific Coast of the U.S. and were mainly Caucasian (83%), although there were some Japanese (10%) and a few Chinese (3.3%) visitors. In terms of marital status, the newcomer sample is significantly more likely to come from the divorced and single group than are either the normal tourist or the normal emergency room psychiatric patient (see Table 2). Similarly, newcomers in the emergency room are much more likely to be unemployed (61.7%) as compared with the unemployment rates of the normal emergency room patient (23.3%) or compared to the westbound tourists who are almost all employed; in fact, whereas 58.9% of the westbound tourists had professional or business occupations, only 15.0% of the newcomer sample did. Thus, those who came to Hawaii and were shortly thereafter seen as psychiatric emergency patients tended to differ from other tourists in that they tended to be younger, single or divorced, and unemployed.

TABLE 2.—*Marital Status of Travelers in Three Studies*

MARITAL STATUS	NORMAL WESTBOUND TRAVELERS	ALL E.R. PSYCHIATRIC PATIENTS	NEWCOMER E.R. PSYCHIATRIC PATIENTS
Married	75.4%	24.7%	15.0%
Divorced	4.3	9.7	20.0
Single	15.8	32.3	58.3
Separated	—	3.0	3.3
Widowed	4.5	3.0	0.0
No data	<u>—</u>	<u>27.3</u>	<u>3.3</u>
Total	100.0	100.0	99.9
N	(5,343)	(300)	(60)

Method

The tourist industry in Hawaii is a billion-dollar enterprise employing 50,000 people. On any given day, there are 60,000 tourists in the small state, one for every 14 permanent residents⁷. In 1951 there were only 90,000 visitors to Hawaii, but by 1974, the tourist influx had grown to an estimated three million people annually^{8,9}. Who are these people, where do they come from, and who among them comes to a hospital emergency room for psychiatric help?

Data were collected from the emergency room and mental health clinic of Queen's Medical Center in Honolulu between July, 1973, and January, 1974, on 60 psychiatric patients who had been in Hawaii for less than three months at the time of admission. This "newcomer" sample, although constituting neither all the recent visitors admitted to Queen's for psychiatric help during this period (estimated at 120), nor a random sample of them, was selected in part on the basis of the completeness of the medical records and the accessibility of the psychiatric staff member who saw the patient. Information on each patient in the sample was obtained by reviewing the emergency room records, records of the mental health clinic, records on the inpatient psychiatric ward, and structured interviews with the staff members who saw the patients. Patients themselves were not interviewed by the researchers, and hence detailed information about them was not available.

Data on the sample of patients in this study were compared with information gathered in three other studies. The first was a survey of all psychiatric emergencies seen at Queen's during a three-month period in 1971¹⁰. The second and third studies were conducted by the Hawaii Visitors Bureau on both westbound U.S. mainland visitors to Hawaii and tourists from Japan^{10,11}. With these data, it is possible to begin to develop a profile of the traveler in crisis and how he compares to non-travelers in crisis and to non-crisis travelers. All comparative data come from these sources.

TRIP TO HAWAII

Where possible, information regarding the patient's preparation for, and the nature of, his trip was obtained, although there was a substantial amount of missing data. Surprisingly, where the data were available, 72% (23 of 32) had prepared for the trip to Hawaii for less than one month, and 28% (9 of 32) had prepared for less than one week. In contrast to the westbound and Japanese visitors' studies, which found over 75% of the travelers came to Hawaii for the purpose of vacationing, only 21.7% of the newcomer patients expressed that motive. Instead, they were much more likely to have come for purposes of relocation (36.7%), to visit (10%), or for other non-categorized reasons. Of the 37 pa-

tients where information was available, 24 (65%) were making their first trip to Hawaii. Most of the patients (30 of 36) had been optimistic about their trip to Hawaii, even though they were generally traveling alone (65%, 35 of 54), and most had no acquaintances in the Islands (55%, 27 of 49). Although in the westbound study¹² 89.0% of the travelers were staying in hotels, only 21.7% of the newcomer patients had such a local residence. They were more likely to be staying in a place of their own (room or apartment), or in a variety of unconventional locations, such as living in cars, on the beach, or being transported directly from the airport to the emergency room upon arrival. In contrast to the findings in the westbound study where 68.7% of the travelers intended to stay less than two weeks in Hawaii, 82% (31 of 38) of the newcomer patients had plans for an indefinite stay. Nonetheless, in less than two weeks, 65% (36 of 55) found themselves in the emergency room for psychiatric help and 84% (46 of 55) were there before one month had elapsed.

The profile that emerges from these data is of a person deciding rather suddenly and on his own to permanently relocate in Hawaii, a place he may not have ever visited, and one where he had no acquaintances or a place to stay.

PSYCHIATRIC STATUS

The most common pathway to the emergency room was to be accompanied by a friend (22%, 11 of 50), the police (18%, 9 of 50), or to come alone (18%, 9 of 50). It was less likely for them to come via more traditional psychiatric routes, i.e., with family, referred by social and health agencies, or by physicians. Fifty-four percent (28 of 52) of the sample had been previously hospitalized, although information on the frequency, duration or timing of the hospitalization was not available. Tentative diagnoses for the sample ranged over the entire gamut. Primary and secondary diagnoses included psychosis (55%), neurosis (28.3%), personality disorders (20%), and substance abuse (11.7%). Surprisingly, only two cases (3.3%) received a diagnosis of adjustment reaction. The presenting problems likewise were diverse, including most prominently, behavioral problems (48.3%), physical complaints (31.7%), and suicide attempts (16.7%).

The picture that emerges of the sample is that the newcomers have had a history of psychiatric problems before coming to Hawaii, and at least half of them presented problems of a psychotic nature. Over 41% of the sample were immediately hospitalized on the psychiatric ward following the emergency room contact, and 28.3% were referred to the psychiatric clinic of the hospital.

Conclusion

A study such as the one reported here can be

only exploratory. As an exploratory inquiry, the study does lead to a tentative hypothesis. The data suggest that the precipitants of the newcomers' psychiatric crises occurred prior to coming to Hawaii. The ill-fated trip to the Islands seems to have been inadequately planned for by the newcomer, who was often young and alone, and who was too hopeful that past problems would be relieved and too optimistic that things

would be better in an island paradise. High expectations, coupled with the difficulties confronted by any long distance traveler, and the rather serious personal shortcomings that this sufficient to bring them to the attention of psychiatric professionals shortly after the travelers' arrival in Hawaii. The evidence suggests that for some troubled people, long distance air travel may provide an illusory flight from madness.

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H. TOM THORSON

Reminders—Pay attention to the July 14, 1975, issue *JAMA*, page 179. The article contains information that could save a lot of trouble as the title is "Hospital Bills that Medicare Won't Pay"—worth reading!

June issue of *HAWAII MEDICAL JOURNAL* relative to drug dispensing regulations. This is particularly important because reports are that doctors continue to violate the rules and if this goes on we can expect even more stringent controls.

Special Reminder—The HMA annual meeting will be held October 24, 25, and 26, 1975. There will be no scientific sessions this year because of the imminent AMA Clinical Meeting. The House of Delegates will meet in the Mabel Smyth Auditorium. Resolutions and annual reports are due September 24. Suggested Bylaws changes must be submitted no later than August 24.

AMA Wins One and Starts Another—A Three-Judge court rules that the preliminary injunction upheld the District Court ruling giving the injunction against HEW over the implementation of the Utilization Review regulations. The case is remanded to Judge Hoffman for trial on the merits and consensus is that he will declare the regulations to be unconstitutional.

Last week the AMA filed for a restraining order on the proposed rules and regs concerning the Maximum Allowable Cost on drugs. The MAC program imposes strict controls on prescribing and dispensing related to the lowest cost generic item in a given class of preparations. It could be one of the most difficult programs to live with.

Joint Underwriting Association Board of Directors holds first meeting on August 1, 1975.

A draft of the Plan of Operation was presented by the Department of Regulatory Agencies for discussion. A number of changes were suggested and there will be a lot of modifications before the final plan is adopted but there are some features that seem to be generally acceptable, not the least of which is the agreement that the policies offered will be in the "occurrence" form rather than the "claims made" form, so that upon the termination of the plan there will be no gap in the coverage. Underwriting standards, certain fiscal matters and some definitions of terms must be worked out, but the thing is moving. You will be kept informed.

Corrections in Workmen's Comp Rule XXXI—There was an error in the published schedule. Please make the correction in your copy of January 1, 1975 as follows:

Code 72114 \$59.50 (instead of \$34.00).

New Conversion Factors From Department of Health—Reference is to the HMA 1970 RVS—Please note the changes—effective July 28, 1975.

ANAESTHESIA conversion factor of \$6.00

SURGERY conversion factor of \$6.00

DIAGNOSTIC RADIOLOGY (includes

radiation therapy and nuclear

medicine) 2.40

PATHOLOGY30

MEDICINE60

The above represents maximum rates of payment for services under the Department of Health programs.

Department of Health is seeking Medical Directors for Waimano and Kaneohe Hospitals—interested persons should contact Dr. Audrey Mertz—548-7404.

Air National Guard—Dr. Claude Caver, Air Surgeon for the HANG announced that private physicians would care for the Guardsmen on the neighbor islands.

HEW proposes a uniform procedural terminology and coding system of three digits; first digit to denote level of complexity. Isn't it an amazing phenomenon how little understanding planners and bureaucrats have relative to medical care? AMA has filed a strong protest.

President Winfred Lee is in Las Vegas for conference on malpractice.

Weinberger statement on proposed MAC regulations was published in all newspapers and resulted in our Pharmacy Committee Chairman, Vince Aoki being cornered by the news media for a statement.

Hospitals May Require Insurance to be carried by physicians having staff privileges. A decision in a Louisiana court ruled that a private hospital may require that privileges be withdrawn if a physician does not produce evidence of adequate insurance. (Citation June 1, 1975, Vol. 31, No. 4.)

Comp Health Planning report for statewide planning is being studied by Health Care Planning Committee. At first glance it appears to be full of inconsistencies, inaccuracies and erroneous conclusions. Only one practicing physician was on the panel that prepared the plan. (Editorial comment—It would appear logical that so-called or self-styled health care planners should be subject to some standards of training as it seems that anyone that wants to call himself one can become an instant expert.)

JCAH reports there will be no hospitals in Hawaii scheduled for review during the third quarter of 1975.

HMA omnibus bill relating to malpractice problems is being readied subject to approval of the Council. The proposals will be published in full as soon as the material is complete. It will cover in general the topics of tort liability and evidence, claims settlement, and professional discipline. When the final draft is approved, all members will receive a copy and will be expected to support the proposal through contacts with their State Senators and Representatives.

AMA Clinical Session will be in Honolulu, November 30 to December 5. All members should make an effort to attend at least some of the sessions of the House of Delegates as well as some of the scientific sections. Reference committee hearings are an education. Neighbor island members should make their hotel reservations early. If you have a problem, contact Trade Wind Tours—phone 923-2071.

You Can Be Heard—Recently a Honolulu physician objected to the wording of a statement on a Medicare report to the patient, implying that the care given was improper. The Peer Review Committee of HCMS filed a formal objection with copies to the AMA who also intervened and in a letter received from the Executive Office of Aetna, we have been advised that the objectionable material has been withdrawn.



Specialty Recertification Begins!*

Time moves faster than we anticipated and, to many of us, is accelerating quite rapidly as 1976 and the first mandatory Recertification examination in medical history—that of the American Board of Family Practice—approaches. To those who are scheduled to participate in this historic event, the prospect may seem a bit grim. In truth, the eventual satisfaction of having contributed to a major occurrence in the history of medicine will far outweigh the anxieties and efforts involved in preparation for and participation in Recertification.

Before pursuing this point further, it is best that I review, briefly, the real purpose of Board Certification in an area of medicine. In spite of the misuse and abuse of the concept of Board Certification in granting hospital privileges, this is not the reason for its existence. Accomplished goals of Certification include: (1) increased quality of education in the graduate (residency) programs, (2) improved standards of practice in the area of medicine, whether all are diplomates or not, and (3) recognition of those young physicians who have taken special training.

In 1916, the American Board of Ophthalmology became the first certifying board. Since that date, there have been created and recognized 22 Primary Specialty Boards. With their stimulation and under their guidance, graduate education programs have reached a zenith and the American public may feel secure in the fact that young physicians leave the mainstream of organized medical education well equipped.

During the past five years, postgraduate, or continuing, education has proliferated a thousandfold. Some of this postgraduate education has been excellent, some good, some very mediocre, and some unbelievably bad. There are

instances when physicians go to courses and register for credit without attending. It is quite evident now that such an unorganized, expensive, and potentially nonproductive situation for the physician is about to end. With Recertification on the horizon, each specific postgraduate education course will be good or will cease to exist.

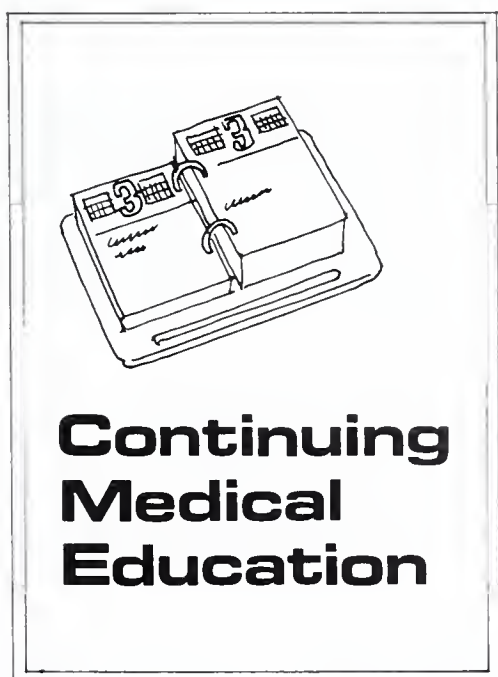
Ophthalmology was the first actively and vigorously to support the concept that graduate education must be of good quality and must be stimulated toward constant improvement. Family Practice, with its mandatory recertification provision, is the first to advocate and support this concept for postgraduate education. Four historic years in medicine are now quite clear: (1) 1756, creation of the first undergraduate School of Medicine in the United States; (2) 1911, creation of the Liaison Committee for Accreditation of Medical Schools; (3) 1916, creation of the first Board for examining and certifying graduate education, and (4) 1976, creation of the first mechanism for examining and certifying for postgraduate education.

Development within each certifying board of a special division for the express purpose of Recertification and stimulation of quality postgraduate education is certain to follow.

The 1970 class of diplomates of the American Board of Family Practice will, in the future, be proud that they have participated in such an event in history and, in fact, have made it possible.

GEORGE E. BURKET, JR., M.D., PRESIDENT
AMERICAN BOARD OF FAMILY PRACTICE

**Reprinted from an open letter to ACFP Members*



AMA Informs Us

The mailing of the 1975 Physician's Recognition Award instruction booklet and application form for the 1975 Award should reach you by the end of August.

There are some significant changes for the 1975 PRA Award:

1. The physician may apply for the Award any time he feels he can qualify.
2. Organizations accredited for CME may designate which of their continuing medical education activities meet the criteria for Category 1.
3. The definition of a planned program of CME is expanded to make it more specific.
4. There is an improved application form.

We'd like to suggest that you jot down the number of hours you spend in CME activities in your daily appointment book so the information will be readily available when it is time to tally the hours for the PRA Award. The criteria for the PRA categories are:

	Credit Hour Limit
Category 1—CME Activities with Accredited Sponsorship (The activities listed in this column are ALL Category 1)	No limit
Category 2—CME Activities with Non-accredited Sponsorship	45 hours
Category 3—Medical Teaching	45 hours
Category 4—Papers, Publications, Books and Exhibits	40 hours
Category 5—Non-supervised individual CME activities	45 hours
Category 6—Other Meritorious Learning Experiences	45 hours

CALENDAR OF ACCREDITED EVENTS—CATEGORY I

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS:

Ongoing

Kauaikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital

1. Tuesdays—CME Program, 1:00-2:00 p.m.
2. Grand Rounds, 2nd and 4th Mondays—5:00-6:00 p.m.
3. Visiting Professor Programs (see Special Events)

Kuakini Hospital

1. Hematology Rounds, Monday, 1:00-2:00 p.m.
2. Gastroenterology, Tuesday, 8:00-9:00 a.m.
3. Oncology Conference, Thursday, 8:00-9:00 a.m.
4. Endocrine Conference, 2nd Wednesday each month, 1:00-2:00 p.m.
5. Medical Statistics, 3rd Tuesday each month, 1:00-2:00 p.m.

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

SPECIAL EVENTS

August 9-20 Eighteenth Annual Postgraduate Refresher Course presented by USC with U of H School of Medicine in association with Tripler (Fee charged)
Honolulu (Sheraton-Waikiki Hotel)
August 9-15; Maui (Maui Surf Hotel)
August 18, 19

- Kona (Kona Surf Hotel)
August 18, 19
Program is on HMA Bulletin Board
Contact: HMA CME Office or U of H
School of Medicine for further information.
- August 27 Program on Dysfunctional Uterine Bleeding.
Contact: G.N. Wilcox Hospital for further information.
- September 7 The Challenge of Interprofessional Communication by Hawaii Medical Association Program and sponsored by Lederle, Ilikai Hotel, 9 a.m.-4:30 p.m.
- September 8-12 Practical Management of Anesthetic Problems. USC at Mauna Kea Beach Hotel.
- September 11 Kuakini Hospital 75th Anniversary Celebration Seminar for Physicians, 7:30 p.m., University of Hawaii Biomedical Science Building, Room B-103.
Contact: Vincent Aoki, M.D., Director of CME, Kuakini Hospital, Phone 536-2236.
- September 17-19 *Pediatric Post-Graduate Neurology Seminar* at the Princess Kaiulani Hotel. Highlighting the symposium will be Dr. Sidney Carter, Professor of Neurology at the College of Physicians and Surgeons, Columbia University, and Dr. Richard Schain, Professor of Neurology at the UCLA School of Medicine. Pre-registration at the Department of Pediatrics office of Children's Hospital. Registration fee.
- September 21 "*Hypertension*" sponsored by Hawaii Heart Association and Hawaii Medical Association; at the Princess Kaiulani Hotel, Honolulu, 8:00 a.m.-3:30 p.m. Registration fee. Contact: Molly Austin, 538-7021.
- September 27-28 The Medical Director in the Long Term Care Facility sponsored by Hawaii Medical Association through a grant from Region IX Department of HEW, Mabel Smyth Building, beginning at 1 p.m. on Saturday.
Contact: Bess Chang, HMA Office, 536-7702.
- September 28 Conference on Alcoholism, "New Diagnostic and Treatment Methods," sponsored by Hawaii Psychiatric Society, APA, HMA, Department of Health, University of Hawaii, Ala Moana Hotel. Registration fee. Contact: Bernice Coleman, M.D., phone 737-7811.
- September 27-October 4 Workshops in Gynecologic Oncology, High Risk Pregnancy and Endocrinology-Inertility. UCSF at Maui.
Contact: Malcolm Watts, M.D., School of Medicine, University of California, San Francisco 94143.
- September 30 Hawaii Thoracic Society annual Fireside Chat: Current Concepts in the Pathogenesis of Chronic Pulmonary Disease by Dr. W.G. Johanson, Jr. from University of Texas Health Science Center; Ala Moana Hotel, Vanda Room; 7:30 p.m. Will also present programs on neighbor islands: September 29, 8:00 a.m. at Wilcox Hospital; October 2, 7:00 a.m. at Maui Memorial Hospital; October 3, Noon, Hilo General Hospital; Honolulu hospital programs to be announced. Contact: Gary Houghtby, 537-5966.
- October 20-24 Pathology Review. USC at Mauna Kea Beach Hotel.
- November 29-December 5 American Medical Association, 29th Clinical Convention, Sheraton Waikiki, Honolulu.

Contact: Frank A. Gray, AMA Convention, Services Department, 535 N. Dearborn St., Chicago, Illinois 60610.

- December 5-9 International College of Surgeons, U.S., Section Annual Meeting, Sheraton Waikiki, Honolulu.
Contact: Marilyn Lento, PRC, International College of Surgeons, 1516 Lake Shore Drive, Chicago, Illinois 60610 or HMA (CME Office)

- December 5-11 Cleveland Academy of Medicine, Kona Surf/Sheraton Maui.
Contact: Donald Mortimer, 10525 Carnegie Avenue, Cleveland, Ohio 44106.

1976

- January 18 Medical Emergencies in the Elderly, presented by the American Geriatrics Association and the HMA, to be held at Straub Clinic, 8:30-4:30. Speaker: Thomas Criley, M.D.
Contact: L. Clagett Beck, M.D., 523-2311.
- February 15-19 Sports Medicine for Primary Physician; Lihue, Kauai; Hawaii Medical Association EMS Program.

1978

- April 1-7 Pan Pacific Surgical Conference, Hilton Hawaiian Village.
Contact: Cesar B. deJesus, M.D., Pan Pacific Surgical Association, 236 Alexander Young Building, Honolulu, Hawaii 96813.

OUT OF STATE:

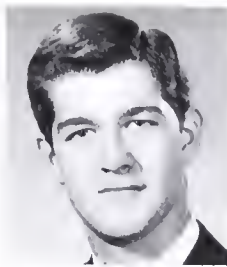
American College of Physicians: regional meetings as scheduled below:

- September 12-13 a) Wyoming, Jackson Lake Lodge, Grand Tetons
b) South Dakota, Rapid City
c) Wisconsin, Merrimac
d) Alabama, Point Clear
e) Washington, Seattle (Olympic Hotel)
- September 22-24 Minnesota, Rochester (Mayo Clinic)
- September 22-26 California, Pasadena
- September 26-27 Ohio, Mansfield
- September 26-28 Michigan, Gaylord
- October 2-4 California, Los Angeles (Beverly Hilton)
- October 4 Maryland, Baltimore (U of Maryland)
- October 8-10 Pennsylvania, Philadelphia
- October 9-11 Oklahoma, Grove
- For further information: American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.
- October 26-30 Annual Assembly of the American College of Chest Physicians, Anaheim, California.
Contact: Alfred Soffer, M.D., Executive Director, Am. Col. of Chest Physicians, 911 Busse Highway, Park Ridge, Illinois 60068

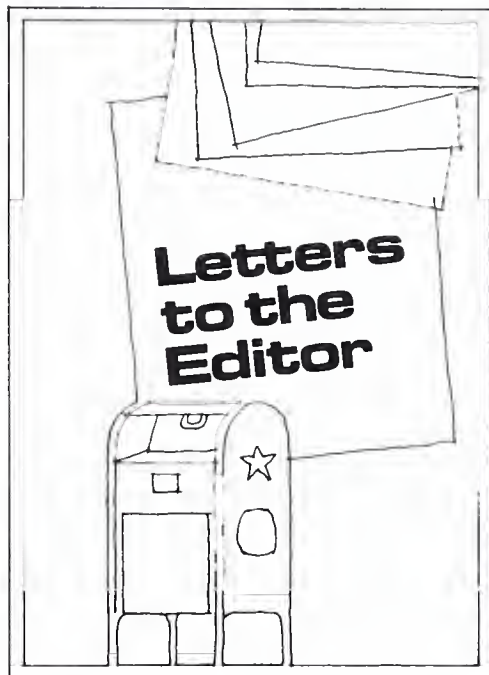
A.G.P.A. ANNUAL MEETING

American Group Practice Association will be holding its annual meeting at the Sheraton Waikiki Hotel from October 27 through October 31, 1975.

All sessions will be held in the mornings. Interested persons or groups should contact: Dr. R.T. West, 888 South King Street, Honolulu, Hawaii 96813; or call 523-2311.



Kenneth H. Kern, M.D.
1481 South King Street
Honolulu, Hawaii 96814
FAMILY PRACTICE



To the Editor:

Comments in the "News & Notes" column of the most recent *Hawaii Medical Journal* Vol. 34, No. 7, July 1975, about the Kona Hospital situation and Jack Morris disturbed me because they point up an attitude that I feel needs some correction. This immediate, defensive attitude, which develops before any objective consideration of the malpractice situation is, of course, not limited to doctors. However, we are only responsible for our own behavior.

Without commenting upon the merits of any case mentioned in the column, I believe that we physicians must be willing to examine cases of litigation and learn from each case, rather than immediately taking an unqualified defensive position. Certainly "a string of malpractice suits" would warrant examination of attitudes and practices to see whether or not weak points that encourage suits might truly exist.

Furthermore, supporting state protection against suits is in effect, encouraging socialization of medical practice. Is this what we really want?

MARION L. HANLON, M.D.
Maui Medical Group, Wailuku



Nathan Batt, M.D.
2230 Liliha Street
Honolulu, Hawaii 96817
FAMILY PRACTICE



Julia Ann Frohlich, M.D.
Queen's Medical Center
Honolulu, Hawaii 96813
PATHOLOGY



Robert Gottesman, M.D.
888 South King Street
Honolulu, Hawaii 96813
EMERGENCY ROOM

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Hawaii Academy of Family Physicians' Newsletter

J. I. FREDERICK REPPUN, M.D.

New Members—**Bert Baysa** of Wahiawa has a nephew and his name is **Jeff Baysa** and he is UHSM II, Class of '78 and has joined us as a Student Member. **Kathleen Myers** is another new Student Member and from the same class at UHSM; she is a Vice-president of the local chapter of AMSA. Both came to our last dinner meeting the end of June and must have liked what they saw of us. We welcome you into our ranks!

Dropped—from the roster was **Alan J. Chun**, Student Member at UHSM, for non-payment of dues.

Change of Status—from Inactive to Life: **Ewart Sarvis MD**, long-time retired physician in Kailua-Kona. Ewart joined the Academy in March 1951—24 years ago. The Council was happy to accord him Life membership, and to learn that he is sticking with us.

News of Members—**Felix Lafferty** and **Fred Reppun** have been certified by the Secretary as official Delegates to the 27th Annual Convention in Chicago on October 4. **Bill Kirker**, former member and long-time physician in Niger, Africa, was assisting **Fred Dodge** in the Waianae Comprehensive Health Center until he has his future plans mapped out. **Wilmot Boone** of Kealahakua, Hawaii, spoke up for Medicine in a Letter-to-the-Editor (Advertiser 7/9/75) and suggested it might be more appropriate for Medicine to examine and supervise the Legislators than for Government to impose ponderous dictates upon our profession. It was a beautiful wedding, high up on a grassy bluff that is the Kahuku Golf Course 4th Tee, overlooking beautiful Malaekahana Bay. It was blessed in the fashion of the Hawaiian Ali'i when a quick, cool, refreshing rain squawl came in on the whistling Tradewinds just as the nuptials were being joined. **Marc Shlachter** was married to Donna Adversalo. Many of Marc's colleagues came to enjoy wedding and feast, the latter at the Kuilima. Marc has a great future as physician for the North Shore; the Samoan community had previously made him a High Chief.

Mike Padwick Speaks Up!—and he got results. Both Puerto Rico and Hawaii have been given a 30-day extension in replying to "Clinical Quiz" in the American Family Physician magazine. Mike reported he gets his magazine in Kapaau, Hawaii, 15 days into the following month, so cannot possibly submit his answers by the end of the issue month.

H.M.S.A.—by laborious count of the recently published list of participating physicians, 52 of our actively practicing members are on their list as "Pars."

CORE Content Review—we stand corrected: The P Credit hours are 24 for the 1975-1976 course—and NOT 18 as we stated.

Next Dinner Meeting—will be on September 13. Watch for further announcement.

"The care of human beings ultimately comes down to a very small number—specifically, one."

So says David Leigh Rodgers, M.D., Chief of Staff at the Presbyterian Hospital in San Francisco (*Center Magazine* July/August 1975).

But "Government characteristically deals with large numbers, very large numbers", he goes on to say, as he asks whether the vast system of health care a-building in the Nation's capital can focus on that one individual.

A "Cottage industry", is what Dr. Rodgers labels the system within which the profession has labored in the past. By that he means we physicians have worked as individuals, as lords and masters of our own bailiwicks. This is praiseworthy—particularly so in terms of the focus on the "one" patient. Nevertheless, there is increasing criticism, mostly generated by the social and public health planners, that too many citizens are being denied access to this exemplary system, and that this denial is mainly on the basis of price.

Is this true? If the reader is prone to deny it vehemently (the AMA certainly does!), does he harbor a faint inner uneasiness and doubt? What about our current problems with the DSSH, our reluctance to accept their clients as our regular patients?

When "they" speak of denial of access, what is really meant is that the door to the system may be open enough, except that the desired special, personal, one-to-one, doctor-patient ingredient is missing. "They" do not realize that it is missing because the cook (the government) has deliberately left it out of the recipe.

Rodgers goes on to point out that the national effort is misdirected towards an emphasis on the structure of the edifice of the "new formula for health care", and that it ignores the contents and particularly the essential focus on the patient, the "one".

Rodgers correctly understands that all pre-paid comprehensive plans and groupings—HMO's and their prototypes—require the physicians within to withhold or ration the "time-consuming, humanistic" extras that are so essential to the relationship between the physician and his patient in order for the latter to be "cured". Efficiency and cost-control demand this withholding. The physician in such a system is not allowed to have a total commitment to his patient; he must withhold a measure of his concern for the patient's welfare; he must save a portion of his empathy for the solvency of his organization and for his partners in it. The well and the worried well, even though they make up half of any physician's practice, are more likely to get short shrift under such a system.

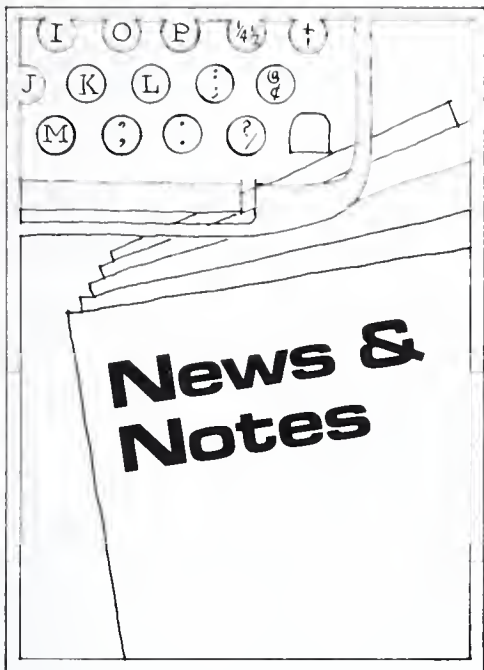
There is a great deal more food for thought in Rodgers' excellent article entitled: "The Moral Provider", including an analysis of how the physician, largely through his own acquiescence and that of his organization, the AMA, made himself subject to the medical insurers, the newest and largest of which is our government, when he, in fact, need not have involved himself at all in the contract between his private patient and the third party.

Allow me to quote from Dr. Rodgers' conclusion (slightly paraphrased):

"Physicians...permitted themselves to be termed 'providers' and their patients 'consumers' as they have:

- Cooperated with insurance companies which, at the moment of payoff consider their subscribers fraudulent;
- cooperated with inadequate government programs which tell them what they can and cannot do for their patients;
- cooperated with prepayment schemes which honor the economics of the delivery system above the humanistic needs of the individual person."

JIFR



HENRY N. YOKOYAMA, M.D.

Life In These Parts

Harry Arnold Jr. wonders why women's libbers have not objected to astronaut Neil Armstrong's statement as he took

his historic first step on the moon. They should have insisted on "A giant step for personkind" rather than "A giant step for mankind." Harry also says, "If they are going to insist on chairperson for chairman, why not woperson for woman?"

Mel Kaneshiro, Kuakini Chief of Medicine, suggests, "We should have topless nurses in CCU... Then we can determine earlier whether or not the patient is going to make it..."

A 58-year-old man with a large left-lobe hepatoma died after resection because the remaining right lobe was badly cirrhotic. Pathologist **Grant Stemmerman** commented on his necropsy findings: "You can't make a silk purse out of a sow's ear..."

Kapiolani Hospital had its first Leboyer delivery in July, but **Carl Morton**, the attending was less enthused than the mother. The Leboyer method, developed 10 years ago by a French OB man, reduces the impact of birth trauma to the child by dimming delivery room lights, by keeping conversation to whispers, by allowing the child to deliver at his own pace, by avoiding the use of forceps, by not spanking the child to induce crying, by delaying the cutting of the cord till pulsation stops, and by supporting the child in a tub of lukewarm water after the cord is cut, to remind him of his previous environment. All this to reduce the child's anxiety caused by birth trauma. Carl does not think the method "so great that it should supersede what we already do." He also says, "I don't think we are terrifying babies with our present delivery techniques."

Straub dermatologist **Robert Kim** and two research as-

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MAKANA FOUNDATION

sistants from the Pacific Health Research Institute recruited 40 "palefaces" at \$20 each to lounge for 2 hours one July Sunday afternoon in their swim suits on chaises around the Ala Moana Hotel pool. The object: to test a new sun screen product against another preparation. Bob mentions PreSun, Eclipse, and Sea 'n Ski as effective sunscreen products and warns "A deep tan may look healthy, but excessive exposure to ultraviolet radiation in fact can be harmful, and if that doesn't scare you off, maybe the fact that you'll wrinkle like a prune might."

At **Marc Schlachter's** wedding feast at the Kuilima on the North Shore: **Sharon Bintliff** in a tee-shirt emblazoned with all kinds of street signs etc.; right across the front: "Milk and Cream", one word over each breast! No matter what the law says, there IS a difference between men and women, Women's Lib to the contrary notwithstanding. (and, to quote the French: *vive la différence*.)

And, on the street sometime soon after, a wahine, quite well endowed, hardly needed the emphasis of a weight lifter on her tank-top front, a bar bell bilaterally situated, and strategically, too.

(Contributed by **Fred Reppun**)

Miscellany

The American ambassador dispatched to a new Asian nation, asked the head potentate, at a reception, "When did you have your last election?" "Just before breakfast" came the intriguing reply . . . (By **Jon Won**, Pacific PSRO project director)

According to biblical lore, the apple hanging from the branch caused the original sin by Adam and Eve, but **Sue Anzai**, our HMA receptionist, says "the pear lying on the ground is really to blame . . ."

The MC at the reception beseeched the newlyweds to go on a honeymoon for one, two, three or even up to six days, but *never* for seven days since this would make the whole week... (As heard by **Irene Wong**, our HCMS secretary)

Professional Moves

Even in this year of the Hare, characterized by timidity and lack of flux, we happily note our annual July-August influx of new physicians. The Kaiser Group added radiologist **Norman Ikemoto** and cardiologist **Kent Kreisman** to its 1697 Ala Moana Blvd. offices, GP **David Livingston** to its Kaneohe clinic and GP **Martin Hoffman Jr.** to its Niu Valley clinic. The Central Medical Group at 1481 So. King St. added internist **Owen Kaneshiro** and OB man **Norman Sato** to its ranks and the Honolulu Medical Group added nuclear medicine man **Richard Littenberg** and general surgeon **Peter Halford**. Pediatrician **Benjamin Chang** joined the Pearl City Medical Associates Inc., orthopod **Robert Nemechek** moved to Kailua Professional Center and psychiatrist **Ron Sterling** opened at the Control Data Bldg. at 2828 Paa Street. Honolulu psychiatrist **Pershing Lo** who has been doing part time with the State Hospital was named its new medical director. The position has been vacant since September last year when **George Stern** left and **Aldon Roat** served as temporary director until his resignation, effective July 16.

Tom Thorson's Corner

A Texan died in New York City. The apprentice mortician called the head mortician: "Say, this fella is so big we can't find a box big enuff for him." "Where's he from?" "Texas." "Then give him an enema, and you can fit him in a shoe box."

As Jeb strolled along with his blind date Sally Ann, he asked, "What would you like to do?" She replied, "I wanna get weighed." He spotted a coin operated scale in front of the bank so he hustled her onto the scale, inserted a penny and got her weight. Then he asked again, "What would you

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* **Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash; urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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like to do next?" She repeated, "I wanna get weighed." "But we just weighed you. Why do you still wanna get weighed?" "Because I *wuv* you."

Physicians Speak Up

Alan Pavel was on a panel with attorney Hyman Greenstein on Channel 4 KITI's "Word 4 Word" on July 13 to discuss the medical malpractice insurance controversy. Jim Penoff, Jim Navin, and John Balfour held free medical forums in Aiea, Kaneohe, Waiālae Kahala, and Kalihi in May, June and July. The forums were sponsored by the American Cancer Society, Oahu Unit, and dealt with general breast conditions, breast cancer, and breast self-examination.

Marion Hanlon, president of Maui County Medical Society, wrote the following commentary on the malpractice insurance problem in the Maui News: "Causes of this crisis are multiple... Doctors blame the lawyers for accepting fees contingent upon the amount of the award, and for the tremendous increase in the size of the judgments sought... Lawyers blame the doctors for deteriorating doctor-patient relationships and for poor self-policing to control inadequate doctors... Both groups lay some of the blame on the insurance companies who seem to be reluctant to reveal the true basis for their financial losses... Therefore, multiple solutions must be found... The patients who are truly injured by neglect or poor judgment must be compensated in a reasonable amount. Contingency fees are not without merit for those clients who could not otherwise afford the services of a lawyer, but the percentage going to the lawyer should be kept reasonable. Unwarranted nuisance suits should be eliminated before ever reaching the courts. Doctors must improve the mutual respect that should exist between themselves and their patients and also must improve their own ability to eliminate the occasional 'bad apple' in their ranks who is negligent or incompetent... All of these solutions will require the cooperation of the lawmakers and the courts... Consequently, the doctors cannot carry the ball alone, but must have support from the community as a whole..."

Harold L. Arnold Jr. has strong feelings about the possession of handguns. In an open letter to General Maxwell Rich, National Rifle Association of America, Harry wrote: "I believe devoutly that the possession of a handgun by anyone except a member of the armed forces or the professional police ought to be grounds for imprisonment for up to five years... Handguns are for the purpose of killing other human beings... They are also toys, but they are too dangerous for toys... Of course sporting and antique guns do not need to be banned, but handguns ought to be—totally."

U of H Med School psychiatrists David Kinzie and Richard Markoff have published a paper on sleep disorders. They feel that sleep disorders are among the most common and difficult disorders for a physician to manage. David says, "The easiest thing to say and the most difficult thing to do is 'quit worrying'... If you go to bed and you aren't sleeping well, don't fight it. Get up. Consider this a time you should be awake and use the time to do something you feel comfortable with... Write a letter, read a book, watch the late late show until you're sleepy. When you lie in bed and fight sleeplessness, you simply agitate yourself and become less relaxed... Don't go the pill route... Drugs suppress the dream part of sleep. When you come off the drug, there is a big rebound. Sleep becomes restless, filled with nightmares and agitations, so people take more drugs or drink more, and become hooked on the system. On the basis of psychological studies with long sleepers and short sleepers, there may be two different requirements for sleep; a constant requirement of slow wave or deep sleep, and a separate and different requirement for REM (Rapid Eye Movement) sleep. REM sleep may be required to maintain normal mental and emotional functioning. Individuals differ markedly in their

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Should a specially prepared package insert be made available to patients?

Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration



Dr. James H. Sammons
Executive Vice President
of the American
Medical Association



The idea of a so-called patient package insert has been around for a long time. Many physicians already use written instruction sheets to provide patients with information about the drugs they are taking. And some physicians give verbal instructions; but in too many instances these are what I call eye-glazing exercises. I have seen patients sit with glazed eyes listening to a rapid-fire lecture by a hurried physician who has 20 people out in his waiting room. These patients aren't given sufficient understanding and therefore do not follow instructions. So I think the idea of an official package insert for patients is a good one. Perhaps we should really think of this kind of information simply as an extension of drug labeling.

The benefits of patient involvement

Many physicians may not realize how frequently a patient obtains his drug information from Aunt Tillie or the next door neighbor. And this information is almost always bad or irrelevant to the case at hand. Furthermore, the incentive to go along with a prescribed program is slim if the only reading matter the patient receives, along with his prescription, is a bill.

As an educator I am impressed by the principle that the best way to get someone to do something is to involve him in the process. So the

I think there are advantages as well as some real disadvantages in a patient package insert. When you begin to use semi-medical or medical terms to describe complications or possible sequelae of disease or treatment, you may frighten the patient—particularly since the more highly sophisticated patient is not the one who is going to read the insert. The patient who will read it is the one most susceptible to fright and confusion by the language.

On the positive side, a package insert will probably give the patient better insight into why he is being treated the way he is, and it may give the physician a little bit more time. But it does not remove from the physician the need or obligation to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should be warned of the possibility of serious side reactions—to know what the real dangers are. But it doesn't do a bit of good to indicate that a patient on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that fright engendered by the insert may possibly outweigh the potential good.

Opinion
&
Dialogue

main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is

no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebotrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a pa-

tient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

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REM and slow wave sleep requirements. Some poor sleepers may have a sleep defect rather than a deficiency in the amount of their sleep. They are not meeting their requirement of deep sleep in proportion to their REM sleep."

Sportsmen

Lindy Chun was playing with **Ross Hagino**, **Henry Yim** et al one Saturday afternoon in July at MidPac and his game was putrid. He had strung five double boggies in a row. As Lindy turned his face skyward to ask for divine intervention, manna he received from heaven... For plop! on his nose came a bird dropping. Thus inspired, he shot 6 pars in a row... and could do no wrong...

We met our intrepid sailor **Fred Shepard** and inquired about his sailing. "Oh, I sold my boat... I'm gliding now," he replied. Having read a recent *JAMA* article on hang gliding deaths and accidents, we started to discourage him from this dangerous sport... But he reassured us that he was free gliding in gliders from Makapuu to Mokuleia... So the erstwhile sailor has turned from sailing ocean currents to sailing air currents...

The exploits of **Don Maruyama** and his Ferrera are becoming legend in his own time... **Ray Fujikami** insists that Don was once clocked doing 125 mph on the Freeway, but the officer giving him the ticket put it down as 85 mph "because his superiors will never believe 125 mph." **Max Urata** relates how Don was stopped for speeding wrong way down a one way street. Don told the officer that he was going to the ER on a life and death case. The officer, a natural disbeliever, insisted on accompanying Don to the ER. Arriving at the ER with the officer in tow, Don quite casually asked the ER nurse how his patient was doing. The ER nurse, bless her heart, quickly assessed the situation correctly and replied, "You can relax, Doctor, your patient's doing fine." The officer, fully convinced, left quietly at this point...

Hors De Combat

The malpractice issue rages hot and furious... **Steele F. Steward** (retired), commenting on Senator Inouye's talk, wrote: "The public labors under a misapprehension. Licensure is not a function of the medical society, but is and has been a political one ever since it was instituted by Roger II of Sicily in the 12th Century... The medical society has the power neither to grant "nor to remove the right of an individual to practice, once it has been granted by the state, which does it very reluctantly..."

Lawyer Hyman M. Greenstein in rebuttal of an Advertiser editorial "Medical Malpractice" wrote: "This seems to be the year of 'jump on the lawyers' back'... The existence of the plaintiff bar does not give rise to the basic origin of a medical malpractice case. Medical malpractice cases are caused by two problems: Medical malpractice... Reluctance of the medical profession to admit to errors in judgment and reluctance to testify against brother physicians..."

"Suggestions that, because of the contingent fee system, lawyers seek out or manufacture medical malpractice lawsuits, are wholly without justification... On the contrary, the contingent fee discourages non-meritorious claims... The result of abolishing the contingent fee system would be to limit recovery... to the more affluent persons in our society... Your editorial referencing '70 to 80% of malpractice cases which go to trial are decided in the physician's favor, suggesting that too many cases are poorly targeted' is another improper inference. The reason most of the cases which go to trial result in defense verdicts is because of the general unwillingness of doctors to testify against other doctors... Further, this statistic ignores the great percentage of cases which are settled before trial... Instead of wasting a lot of time or print on who is at fault in the so called 'crisis'—doctors, lawyers or insurance companies—attention should be focused on the rights and remedies of the victims and concentrating on eliminating the causes of medical malprac-

tice... Public accountability, through the vehicle of a lawsuit, will do more to upgrade the medical profession and its services than crying in the newspapers or lobbying in the legislative halls for immunity from responsibility..."

During KITV's "Word 4 Word" interview program, **Alan Pavel** declared that a panel of attorneys, physicians and a judge should replace the jury system in deciding medical malpractice cases. Alan feels that malpractice suits drag for needlessly long periods through current legal channels, and only 14 cents of every dollar awarded go to the victim, while the rest of the money pays for court costs and attorneys' fees. However, Hyman Greenstein, appearing on the same panel, said he was opposed to abandoning the judicial system. Hyman felt that the blame for significantly higher premium costs should not be laid to the system, but to insurance carriers here. "I think we're being ripped off by one or two carriers," Hyman said, "In any event, a solution would be for medical societies to form their own insurance companies." Alan said five medical associations in the nation have done this "and they're all going bankrupt."

In June, HCMS president **Al Chun-Hoon** testified in a State Capitol hearing that "under today's present climate, many procedures which may be beneficial go undone... I think people are still doing what's necessary, but you really have to be real sure whether to do certain things whereas in the past it wasn't as critical when malpractice was not so acute." Al said he is confident that the majority of the State's physicians do not have the worry of a malpractice suit uppermost in their minds. Certainly there is a climate of fear in a sense, but certainly it is not causing doctors to be too much concerned."

Oncology Dialogue

A 77-year-old man with lymphoblastic lymphoma of a tonsil was treated initially with antibiotics and vidarabine till biopsy verified its true pathology. Pathologist **Grant Stemmerman** offered a poor prognosis, viz, an overall 5-year survival of 3 to 5%. Radiotherapist **Ed Quinlan** was equally dismal... "As Grant has stated, this lesion has a poor prognosis. 4000 rads may be locally effective..." Hematologist **Mel Kaneshiro** asked, "How far can we go in staging this fellow with lymphangiograms?" Ed: "There's no point in staging non-Hodgkin's lymphoma" Fellow radiotherapist **Carl Boyer** agreed: "It's fruitless to stage like Hodgkin's. Most centers treat locally and have given up staging with lymphangiography..." Stemmy turned to oncologist **Quint Uy**: "Would you use chemotherapeutic agents?" Quint: "When its systemic, we could use a combination of agents, but not when its local..." The discussion shifted to immunotherapy. Carl asked, "How would you evaluate response to immunotherapy?" Unfortunately immunologist **Ben Gordon** was absent. Stemmy suggested, "Only by large-scale statistical studies." Quint: "Even immunotherapists will state that immunotherapy is ineffective when there is more than a gram of tumor tissue left." Stemmy: "That is very circuitous reasoning... It gets in the realm of religion..."

A 56-year-old woman had earlier admissions for liver scans and needle biopsies which showed only cirrhosis, but finally, on the 3rd admission, the patient had an exploratory lap which confirmed the diagnosis of hepatoma. Radiologist **Don Ikeda** pointed out that her brother had recently been admitted with an epigastric mass which on liver and Gallium scan confirmed hepatoma. Both patients were HAA positive. Stemmy elucidated: "There is a familial pattern in hepatoma and there are five known families in the State... They have a high frequency of antigenemia... As a group, the Chinese and Japanese have a high incidence of hepatitis antigenemia, which is in most instances familial. Nishioka of Japan feels that this is genetic, but there may be maternal transmission from mother to child as it passes the vaginal canal. There is one local family with five cases of hepatomas and ten members with antigenemia. The hepatomas are frequently multicentric..." ■

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Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications for use as follows:

Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus. "Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding. **Warnings:** Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.

Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens

should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.

Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:

nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash

hepatic cutaneous porphyria becoming manifest
Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (e.g. osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.

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Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control.

For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

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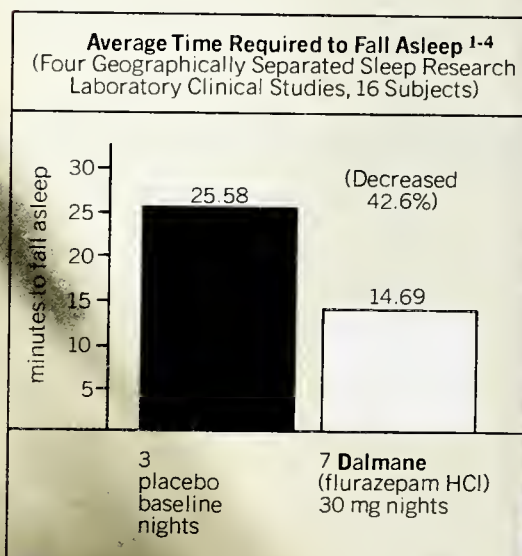
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4. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
5. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ

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Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly

or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

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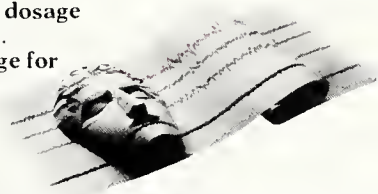
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neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive dis-

orders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anti-convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or

two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

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2. Hollister LE, *et al*: *Arch Gen Psychiatry* 24:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics* 11:438-441, Sept-Oct 1970.

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of child-bearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

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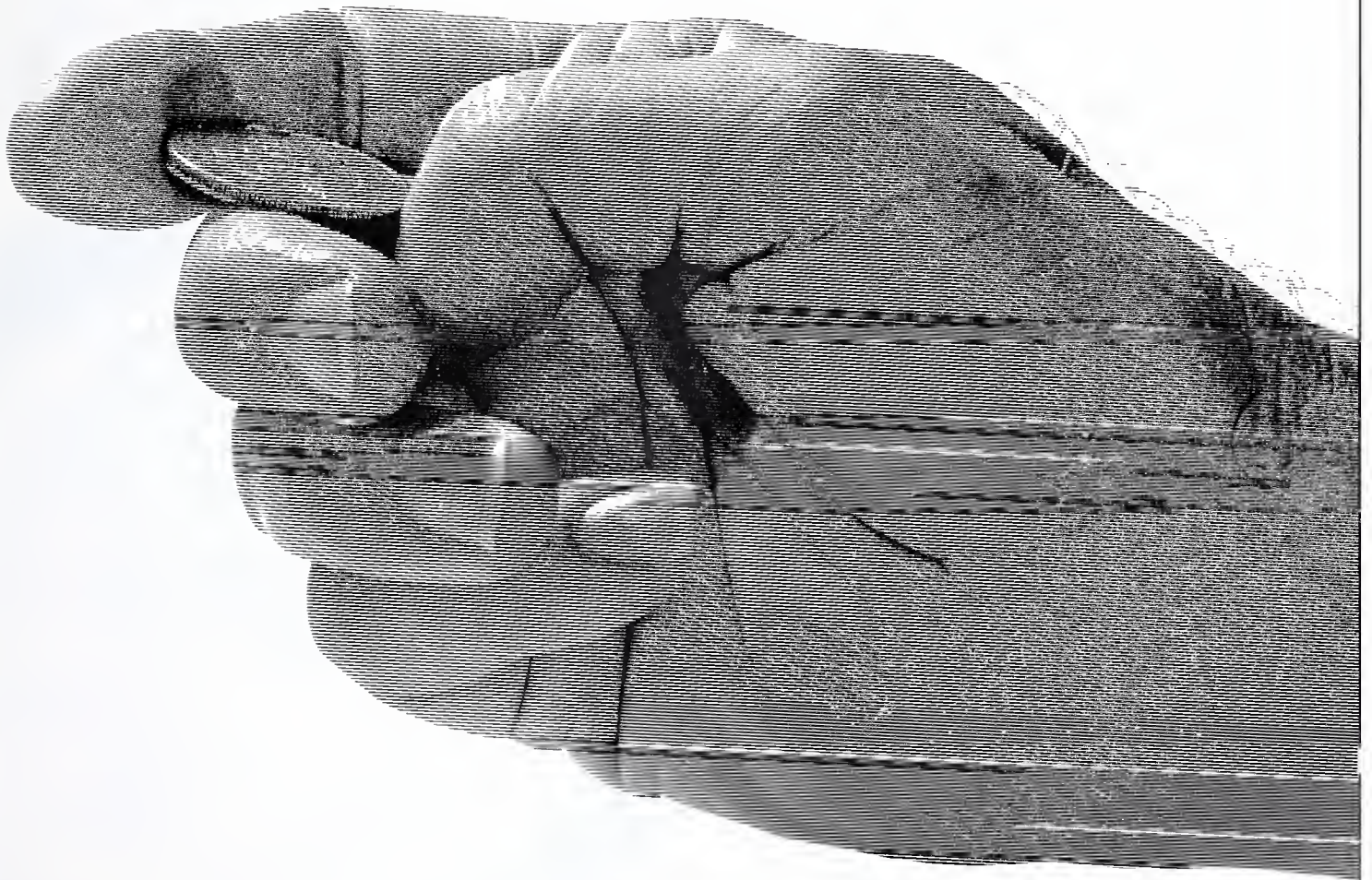
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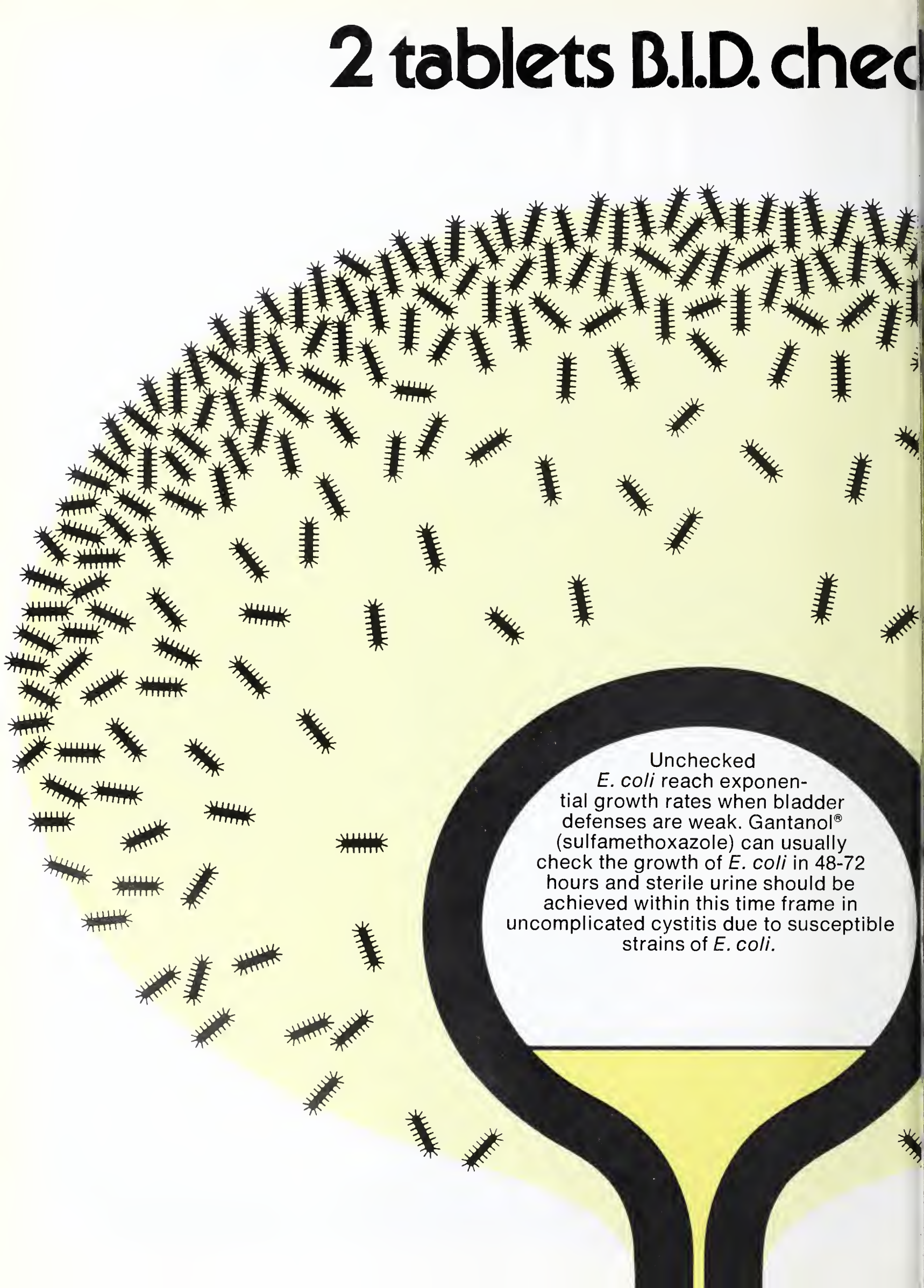
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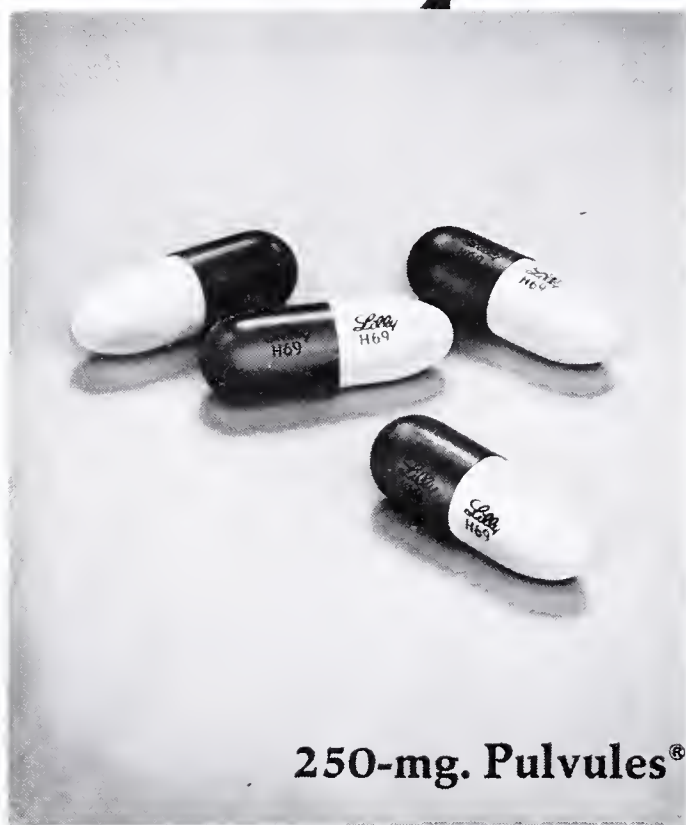
Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

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The Japan-Hawaii Cancer Study: A Progress Report

ABRAHAM NOMURA, M.D.; GRANT N. STEMMERMANN, M.D.;
GEORGE G. RHOADS, M.D.; and GARY A. GLOBER, M.D., *Honolulu*

● *The primary aim of the Japan-Hawaii Cancer Study is to identify risk factors which are important in the development of cancer. Many investigations have been conducted in this long-term prospective study since its inception in 1971. Among the findings to date are the following: 1) bowel transit time does not appear to be related to the occurrence of large bowel cancer; 2) adenomatous and hyperplastic polyps, as well as diverticula, are much more prevalent among Japanese autopsied cases in Hawaii than in Japan; 3) although the incidence of the diffuse histopathological type of gastric cancer does not differ appreciably in Japanese in Hawaii and in Japan, the migrant Japanese have a significantly lower incidence rate of the intestinal type of stomach cancer; 4) hyperplasia of mammary duct epithelia and apocrine metaplasia are more common in Japanese women in Hawaii than in Japan.*

In recent years, Japanese in Hawaii have experienced cancer incidence and mortality rates which are intermediate between the rates of indigenous Japanese and U.S. whites.^{1,2} Because genetic variables are presumably held constant in comparisons between native and migrant Japanese, this shift in the cancer experience of the "westernized" Japanese in Hawaii strongly suggests that environmental factors play a major role in oncogenesis.

Furthermore, this spontaneous socio-medical experiment among the Japanese provides a unique opportunity to isolate specific environ-

mental, biochemical, and pathologic variables which may be etiologically associated with different types of cancerous lesions.

Thus, the National Cancer Institute has supported the collaborative Japan-Hawaii Cancer Study (JHCS), which began in 1971 in Honolulu, Hawaii, and Chokai Village, Akita prefecture, Japan. Since then, the Hawaii phase of this program has expanded to enhance four separate, but interrelated, types of research projects.

THE COHORT STUDY

The cohort study is the principal component of the JHCS program. In Hawaii, the JHCS utilized the study population of the Honolulu Heart Program, which consisted of 8,006 men of Japanese ancestry, born from 1900 through 1919, and examined from 1965 to 1968 on Oahu.³ Compared to men in Hiroshima and Nagasaki, Japan, the Hawaii Japanese men are heavier and taller; have different dietary patterns (higher intake of animal fat and protein); and have higher blood cholesterol, uric acid, and hematocrit measurements.⁴ Approximately 6,800 of the men returned for a repeat examination from 1971 through 1974, and these are the men now under surveillance in the JHCS program in Hawaii.

During the most recent round of examinations, detailed demographic data, as well as information of smoking experience, alcohol use, industrial exposures, and exposures to pesticides, were obtained. A new method for characterization of diet with respect to specific food items has been developed and employed; 33 food items have been tabulated as to frequency and amount of use during the week prior to examination.

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Medical history, particularly with respect to the gastrointestinal tract, was recorded. History of any neoplasm was sought, as well as a medical history of blood relatives. Laboratory studies included electrocardiogram, anthropometric measurements, vital capacity, urinalysis, blood pressure, hematocrit, serum cholesterol, and uric acid. In addition, some blood from each individual was collected for long term storage.

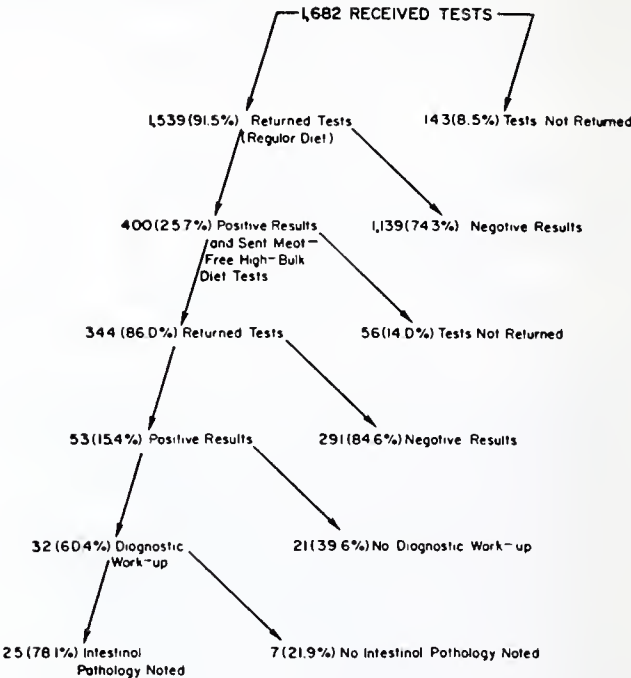
A comprehensive surveillance system of this cohort of men has been maintained in order to identify cases of cancer as they occur in subsequent years. This surveillance has been conducted by a routine review of obituary notices, death certificates and appropriate records from all Oahu hospitals. There are three major end points in this surveillance: 1) the occurrence of new cases of cancer or "precursor lesions"; 2) deaths due to different types of cancer; 3) appropriate pathological findings from surgical specimens or necropsies. The surveillance of this study population has been facilitated by its residential stability and the relative ease in defining its ethnicity and geographic boundaries. It will take five or more years before a sufficient number of cases will accumulate for meaningful analyses of the cohort data. In the meantime, other investigations which have utilized the entire Hawaii cohort of the Japan-Hawaii Cancer Study, have been in progress.

Hemoccult Slide Test

Although great strides have been made in the past in the treatment and management of large bowel cancer, the effectiveness of therapy has currently reached a plateau.⁵ Because of this situation, it was felt that emphasis should be placed on the early detection of bowel cancer by means of the Hemoccult slide test. This test, which utilizes guaiac-impregnated electrophoresis filter paper slides, has been found to be superior to the Hematest (orthotolidine tablet test) and the guaiac reagent test for the detection of occult blood in the stool by Ostrow *et al.*⁶ Furthermore, Gregor⁷ has shown that it is a simple, practical and sensitive method for screening large populations.

The Hemoccult test has been offered to almost all participants of the program. Between October, 1971 (the start of the JHCS program) and August, 1972, 1,682 men received the Hemoccult slide test while they were on their usual diet.⁸ The flow sheet of responses is shown in Figure 1. Four of the 25 subjects with intestinal pathology had asymptomatic cancers. Although it has been demonstrated that this procedure can be done on an outpatient basis by para-medical personnel, it is still unclear if the Hemoccult test can, in effect, reduce gastrointestinal cancer mortality.

FIG. 1.—Flow sheet of responses to the Hemoccult slide test



Diet Restriction for the Hemoccult Test

The peroxidase in hemoglobin is believed to be responsible for the positive reaction of the Hemoccult test. Unfortunately, the following dietary substances also have peroxidase activity: beef, pork, chicken, fish, and certain vegetables. Because of this situation, there is a high per cent of false positives when subjects are not on any diet restriction for the slide test.

The usual recommendation is to place the person on some form of meat-free diet. However, it is unclear what should be avoided in the diet while undergoing the Hemoccult test.

Whereas meat and hemoglobin peroxidase activity persists after boiling, boiling destroys chicken, fish, and vegetable peroxidases.⁹ According to Needham and Simpson,¹⁰ inactivation of the same three types of peroxidases is also achieved by passage through the alimentary canal. These observations suggest that chicken, fish, and certain vegetables, but not meat items, are permissible when undergoing the Hemoccult test. However, the general recommendation is to refrain from eating meats, poultry, and fish while performing the test.⁷ Obviously, if a subject is permitted to consume poultry and fish during the test period, it would be easier for him to adhere to the special diet and it could conceivably improve the degree of cooperation.

In order to determine if there is any difference in the Hemoccult test results by type of dietary restriction, a sub-sample of cohort men were allocated either to a completely meat-free diet or to a red meat-free diet which permitted poultry and fish consumption. A preliminary analysis of the available data is given in Table 1.

It suggests that there are false positive results when chicken or fish is consumed with the He-

TABLE 1.—Hemoccult test results by type of diet restriction.

HEMOCCULT TEST	COMPLETELY MEAT-FREE	RED MEAT-FREE
*Positive	7	18
Negative	80	74
Total:	87	92

*Significantly different at $p < .05$

moccult test, because a false negative result while on a completely meat-free diet is probably a rare occurrence.¹¹

Hepatitis B Antigen

Nishioka *et al*¹² have suggested that there is an association of hepatitis B antigen with hepatocellular carcinoma. With the employment of an extremely sensitive testing system (immune adherence hemagglutination), these investigators found Hepatitis (Hb) antigenemia in 37.3% of Japanese hepatoma patients, as compared to only 2.6% of blood donors.

The annual age-adjusted incidence rate of hepatoma among Japanese men in Hawaii is 6.7 per 100,000, as contrasted to only 1.3 per 100,000 in Miyagi, Japan.¹ In order to determine if the increased incidence of hepatoma among the Hawaii Japanese may also be associated with an increased prevalence of Hb antigenemia, a 1.5 ml aliquot of serum from the cohort men has been sent to Dr. K. Nishioka, Cancer Center Research Institute, Tokyo, Japan. Of 539 Hawaii specimens analyzed to date, only ten (1.85%) were positive. In Chokai, Japan, there were 11 positives (2.94%) out of the 378 tested. This preliminary analysis suggests that the prevalence of Hb antigenemia in the Hawaii Japanese does not account for their higher incidence rate of hepatoma.

COHORT SUB-SAMPLE STUDIES

Because the Hawaii participants of the Japan-Hawaii Cancer program are fairly representative of volunteers of specific ages in the Japanese community, sub-samples of them can provide useful information in conducting comparative studies with other representative groups. Several investigations have been pursued with this goal in mind.

Bowel Transit Time (BTT)

Burkitt found that populations with higher rates of large bowel cancer had slower bowel transit times than populations at lower risk for this cancer.¹³ He hypothesized that the prolonged contact of carcinogens in the stool with bowel mucosa led to the higher incidence of large bowel cancer. Japanese men living in Hawaii have a risk similar to Caucasian men for the development of large bowel cancer.¹⁴ Thus, we would expect that the BTT's of Caucasians and Japanese in Hawaii would also be similar.

A comparison of BTT was made between 63 Japanese cohort men and 23 Caucasian male volunteers. The mean BTT for the Hawaii Japanese was 30.8 hours and for the Caucasians, 53.8 hours.¹⁵ These results were adjusted for differences in educational level, occupation and stool frequency, but the marked differences in the BTT between the two groups persisted. These surprising results were in conflict with Burkitt's well known theory relating colon cancer to BTT.

Fecal Bile Acids and Neutral Steroids

The following hypothesis for the etiology of colon cancer was postulated by Hill *et al*.¹⁶

- 1. the composition of the gut flora depends on the nature of the diet, and in particular on the amount of dietary fat.
- 2. the amount of dietary fat also determines the amount of biliary steroids (cholesterol and bile-salt degradation products) in the colon.
- 3. the intestinal flora is able to produce carcinogens in the colon from biliary steroids.

This hypothesis was based on the observation that stools from residents of two countries (44 in England and 36 in the U.S.) where the colon cancer rates are high showed a higher proportion of metabolically-active anaerobic bacteria and greater degree of degradation of the biliary steroids than stools from residents of three countries (11 in Uganda, 18 in Japan, and 18 in India) where colon cancer rates are low.

Hill *et al* also found that bile acids were degraded to a greater extent in Britishers and Americans. It is of utmost importance that this finding be confirmed, because some degradation products (i.e., deoxycholic acid and apocholic acid) of bile acids have been shown to be carcinogenic.¹⁶ Deoxycholic acid, for example, can be converted to a potent carcinogen, 20-methyl cholanthrene.

The resources of the Japan-Hawaii Cancer Study provide a unique opportunity to test the hypothesis of Hill *et al*. Because the incidence of large bowel cancer in the migrant Hawaii Japanese is greater than that in indigenous Japanese,¹ it would be expected that their fecal chemistries should be different. Therefore, the neutral steroid and bile acid components of feces from Hawaii Japanese and native Japanese men can be compared to test the hypothesis. Furthermore, the Hawaii Japanese can be subdivided into those who consume either a predominantly Western or a Japanese diet.

Fecal specimens from 105 Hawaii Japanese cohort donors have been collected thus far and delivered to Dr. H. Mower of the University of Hawaii, School of Medicine, for bile acid analyses. Each sample is weighed and homogenized, and an aliquot is placed in liquid nitrogen for long term storage. The remaining portion is ana-

lyzed for water content, total fiber, total bile acids, total lipids, total fatty acids, and individual bile acids (lithocholic acid, deoxycholic acid, cholic acid, and chenodeoxycholic acid).

Analysis has been completed on 62 individuals and the results are given in Table 2. To date, specimens have also been collected from 31 persons in Chokai, Japan, and they will be analyzed in the near future. Dr. T. Wilkins of the Department of Microbiology, Virginia Polytechnic Institute, will conduct the neutral steroid analyses.

TABLE 2.—Levels of bile acids in the feces of 62 cohort men including the proportion with a measurable quantity.

	NUMBER OF SPECIMENS	PROPORTION WITH A MEASURABLE QUANTITY	MEAN MILLIGRAMS/GM DRY FECES
Cholic acid	62	.85 (53)	1.66 ± 0.37 *62
Deoxycholic acid	62	.89 (55)	5.69 ± 1.84 *62
Chenodeoxycholic acid	62	.23 (14)	3.06 ± 0.62 *14
Lithocholic acid	62	.89 (55)	2.91 ± 1.14 *62
Total bile acids	62	1.00 (62)	15.14 ± 4.51 *62

± SE
*Number of specimens from which the mean value was determined.

Adenomatous Polyps and Fecal Steroid Conversion

At an earlier date, stools from 18 cohort men with known adenomatous polyps, and from 28 normal cohort men, were sent to Dr. T. Wilkins for neutral steroid analysis. Because adenomatous-polyp patients are believed to be at a greater risk for large bowel cancer than normal individuals,¹⁷ it was postulated that polyp patients would have more extensive conversion of fecal neutral steroids, which have been indirectly associated with a greater colon cancer risk. The results given in Table 3 suggest the opposite: that is, the polyp patients have less conversion of their neutral steroids. A manuscript of this investigation is being prepared for publication.¹⁸

TABLE 3.—Mean percentage conversion of cholesterol and mean concentrations (mg/gm dry feces) of cholesterol and its conversion products, coprostanol and coprostanone, in the feces of 18 Hawaii-Japanese polyp cases and 28 controls.

NEUTRAL STEROIDS	POLYP CASES	CONTROLS
Cholesterol	9.3	7.0
*Coprostanol	5.0	14.6
*Coprostanone	0.4	1.3
*Total animal steroids	14.7	22.9
+*%Cholesterol converted	36.7	69.4

*p < .05, calculated with the Mann-Whitney U-test (two-sided)
+ %Cholesterol converted = (coprostanol + coprostanone) x 100 / Total animal steroids

Bacterial Fecal Flora

As previously mentioned, it has been postu-

lated that intestinal bacteria might be able to produce carcinogens from bile steroids and that variations in the incidence of colon cancer might depend partly on differences in the composition of the intestinal bacterial flora brought about by differences in diet. Because there are identified differences in the diet and large bowel cancer incidence between indigenous and Hawaii Japanese, it is important that an attempt be made to characterize the composition of the intestinal flora in these two groups. W. E. C. Moore of the Anaerobic Laboratory, Virginia Polytechnic Institute, has undertaken this difficult task. He has analyzed 20 stool specimens, collected and processed anaerobically from a sample of cohort men. These data have been published¹⁹ and will be used subsequently for comparison with the flora of other groups of people. A major difficulty in this study has been the presence of a large number of fecal bacterial species, many of which have not been previously identified.

HL-A Antigens and Gastric Cancer

This investigation is to determine whether or not there is an association between HL-A antigen subtypes and the histopathologic categories of gastric cancer, based on the Jarvi-Lauren classification. It is hypothesized that the diffuse category, which is more related to genetic factors²⁰ (viz, increased likelihood of blood type A) is associated with specific HL-A subtypes, while the environmentally-influenced intestinal-mixed-other (IMO) category is not.

As gastric cancer cases among Hawaii Japanese are identified in Kuakini Hospital, blood is drawn with their private physician's approval and sent for HL-A typing to Dr. P. Terasaki (UCLA), who is not aware of the histopathological category of the gastric cancer cases. These results will be compared with the HL-A pattern of a representative sample of approximately 200 cohort men to see if diffuse gastric cancer is related to specific HL-A subtypes.

Diet Validation Study

There is increased interest in the possible role of diet in the etiology of cancers of the large bowel,²¹ stomach,²² and breast.²³ In the past, such studies have usually been limited to gross indirect comparisons of the international rates of cancer with nutrient consumption. Recently, Haenszel *et al* have published findings from case-control studies conducted in Hawaii, suggesting that eating of pickled vegetables and dried fish is associated with stomach cancer,²⁴ while consumption of beef and string beans is linked with large bowel cancer.²⁵ These dietary studies are provocative, but the problems related to the possible bias of patients, as well as the problems which arise from the study of a very large number of dietary variables, were recog-

nized by all concerned. To confirm these results, prospective studies of dietary factors and cancer were indicated. The present dietary study method, based on the tabulation of frequency and amount of use of 33 specific food items, has been developed by Dr. J. Hankin of the University of Hawaii School of Public Health, to accomplish this purpose.

To validate the dietary method, a 7-day diary was collected on 50 cohort men. Interviewers visited each subject and his wife at their home 8 or 9 days before the scheduled examination. A series of 7 dated forms for recording the frequencies of the 33 food items included in the third exam dietary questionnaire were given to the subject, along with pictures of small, medium, and large servings. The men were asked to record the frequency and serving size for each of the food items listed.

When the subject reported for his regular third examination, he brought the diary materials with him. These were not examined immediately, but the regular procedure of eliciting a 24-hour recall and a recall for the past week for the 33 diet items was followed. Subsequently, these recall data were compared with the diary data that the subjects had recorded. These results are described in detail in a manuscript which has been submitted for publication.²⁶

Briefly, there was good agreement (better than 80%) for nearly all the food items, as to whether or not the subject had eaten them, for both the 24-hour and the 7-day recall periods. The usefulness of the 24-hour recall was limited by the fact that many subjects had not eaten many of the food items during the preceding day, whereas many more of the items had been consumed during the preceding week. Rank order correlation coefficients (Spearman) were mostly in the range 0.6-0.9 for the 50 men, though they ran a little lower when men who had not eaten a particular item were excluded. Obviously, there is a moderate amount of misclassification in all diet analyses, but the level of agreement between the written diaries and the recall method used for this study was generally reassuring.

SPECIAL STUDIES

Other investigations have been conducted without direct utilization of the men in the cohort study. Special arrangements were made to identify and recruit the appropriate subjects for these studies.

Gastric Test Battery (GTB)

The objective of this study is to identify a battery of blood tests to serve as a screen for the presence of stomach lesions which are suspected of being "precursors" of gastric cancer. These include atrophic gastritis and intestinal meta-

plasia.²⁷ The GTB consists of assays for serum gastrin, serum pepsinogen I and II, and parietal-cell and thyroid antibodies. Presumably, these blood tests are related to the presence of one or more of the "precursor" lesions.²⁸

Private patients of Japanese ancestry who had gastroscopy at Kuakini Hospital with biopsy specimens taken from the following three sites were identified:

1. proximal to the incisura on lesser curvature
2. greater curvature, prepyloric region
3. greater curvature, mid-way between cardia and the middle of the greater curvature to the point opposite site #1

With their private physician's approval, those patients without a past history of gastric surgery or allergy to eggs were asked to participate in this special study.

Approximately 60 gastroscopy patients have completed their GTB, out of 100 to be scheduled. Gastrin and pepsinogen determinations are performed at UCLA (Drs. J. Walsh and M. Samloff, respectively) and parietal-cell and thyroid antibodies are measured at Kuakini Medical Research Institute. After 100 gastroscopy patients have completed their GTB, we will analyze the data to see if there is a correlation between the GTB results and the gastric biopsy findings.

Female Hormones

Women of London are at high risk for the development of breast cancer; Tokyo women are at low risk; and the Hawaii Japanese have an intermediate risk. It would be of interest if the hormonal profile of representative samples of women of various age groups from the three geographic areas could be determined. In order to accomplish this goal, 66 Hawaii Japanese women in the adolescent, child-bearing, pre-menopausal, and post-menopausal age groups have been examined, with the collection of urine and serum for analysis. Samples of serum were sent to Dr. F. Greenwood of the Department of Biochemistry, University of Hawaii, School of Medicine, for analysis of pituitary hormones, and samples of urine and serum to Dr. R.W. Bulbrook, Imperial Cancer Research Fund, London, England, for analysis of estrogen and androgen fractions. The results will be compared with data from women of the same age groups from London and Tokyo.

MacMahon *et al* recently published findings from a similar study design which suggests that a low urinary estriol proportion (estriol/estrone + estradiol + estriol), especially among young women, is a correlate of subsequent breast cancer risk.²⁹ It is important that this finding be confirmed by others.

PATHOLOGIC AND CELL KINETIC STUDIES

In spite of the possible problems of selection

bias, pathologic studies which compare findings among the Japan-Japanese and the Hawaii- Japanese can be very informative.

Stomach Cancer

A comparative study of 407 gastric cancer cases in Miyagi prefecture, Japan, and 256 Japanese cases in Hawaii, indicated that the estimated incidence rates for diffuse carcinomas were the same in both localities; but the corresponding rates for intestinal, mixed, and other (IMO) types were substantially lower in Hawaii.²⁰ This is shown in Table 4. The results strengthen the hypothesis that intestinal and diffuse types of gastric carcinoma are separate entities and that the intestinal type is related to environmental factors and the diffuse type to host-related factors.

TABLE 4.—Estimated* incidence of stomach cancer per 100,000 population per year by age, sex and type: Miyagi and Hawaii.

AGE	TYPE	MEN		WOMEN	
		MIYAGI	HAWAII	MIYAGI	HAWAII
15-49	IMO	15.4	5.3	6.4	1.6
	Diffuse	9.5	10.	12.8	15.6
50-59	IMO	180.2	45.2	75.7	12.1
	Diffuse	64.6	42.2	32.4	36.5
60+	IMO	457.4	216.1	171.1	94.9
	Diffuse	83.3	109.6	66.2	48.6

*Based on incidence rates in "Cancer Incidence in Five Continents," Volume II, UICC.

Further studies at Kuakini Hospital have suggested that there is a close association between intestinal metaplasia of the gastric mucosa and both gastric ulcer and carcinoma.³⁰ Other studies have shown that intestinal metaplasia has structural and functional differences from normal gastric and intestinal epithelium.³¹ Gastric ulcers favor sites in the stomach most frequently and most heavily involved by both carcinoma and intestinalization.

Organ culture studies of gastric tissue from surgical specimens suggest that re-epithelialization of ulcer craters is effected by actively motile cells at all levels of differentiation and that mitotic activity is suppressed during migration but increased in the intact tissues adjacent to the ulcer. It is, therefore, reasonable to explain the development of carcinoma at an ulcer margin on the basis of coincidental tumor induction of metaplastic epithelium at this margin rather than of regenerating epithelium at the tumor base.

Colonic Neoplasms

Specimens of large intestine from Hawaii Japanese necropsy subjects are being fixed in a buffered formaldehyde solution (10% formalin) in the undistended state after rough washing, and preserved in formaldehyde solution in an organ bank according to the Stemmermann and

Yatani protocol.³² Thus far, we have examined 202 large bowel specimens of Hawaii Japanese. A similar study by Drs. E. Satoh and N. Sasano of Miyagi Prefecture, Japan, was performed with 293 and 187 autopsy specimens from Miyagi and Akita, respectively. The results in Table 5 indicate that diverticula, and adenomatous and hyperplastic polyps, are markedly more prevalent in the necropsy cases of Hawaii Japanese than in their counterparts in Japan.

TABLE 5.—Percent of Hawaii, Akita, and Miyagi autopsied specimens with adenomatous polyps, hyperplastic polyps or diverticula.

	ADENOMATOUS POLYPS %	HYPERPLASTIC POLYPS %	DIVERTICULA %
Hawaii	61.0	76.0	52.0
Akita	30.0	3.0	1.0
Miyagi	19.0	2.5	0.6

In comparison to adenomatous polyps, hyperplastic polyps are found more often in the sites favored by large bowel cancer in the Hawaii Japanese. These include the sigmoid and recto-sigmoid regions of the large intestine.³²

Ultrastructural and cell kinetics studies of hyperplastic polyps indicate that their mode of cell renewal is the same as that of normal mucosa but with a longer turnover time and delayed migration.³³ The superficial cells are longer and have increased numbers of large microvilli. These findings suggest that such cells are hypermature. If they are functionally more efficient than normal surface cells, it would be possible to explain their site association with cancer on the basis of more effective absorption of carcinogens.

Precursor Lesions of the Breast

There is clear evidence that breast cancer is more common among Hawaii Japanese women than among Japanese women in Japan.¹ In order to make a comparison of the changes of the breasts in native and migrant Japanese women, the left breast of necropsy subjects in Japan and Hawaii has been studied by Dr. N. Sasano. He has devised a method involving tissue radiographs of serial slices to estimate the volume of the mammary gland and to detect subclinical lesions that were later corroborated by histologic examination.

The preliminary results from 49 Hawaii Japanese and 55 Japan necropsies are shown in Table 6. Hyperplasia of mammary duct epithelia and apocrine metaplasia seem more common in

TABLE 6.—Comparison of Japan and Hawaii breast specimens by pathological findings.

	JAPAN	HAWAII
No. of Cases	55	49
Carcinoma	0	0
Proliferative Lesion	6	14
Apocrine Metaplasia	5	19
Calcification	4	5

TABLE 7.—Percentage of proliferative type of latent carcinoma among the Japanese in Japan and Hawaii.

	NO. OF SPECIMENS	JAPAN LATENT CARCINOMA PROLIFERATIVE TYPE		NO. OF SPECIMENS	HAWAII LATENT CARCINOMA PROLIFERATIVE TYPE	
		No.	%		No.	%
50-59	57	3	5.3	28	2	7.1
60-69	61	3	4.9	53	7	13.2
70-79	82	7	8.5	35	6	17.1
80+	39	7	17.5	42	18	42.9
Total	239	20	8.4	158	33	20.9
Age- adjusted %			8.7			19.1

Hawaii than in Japan. Furthermore, the breasts of Hawaii Japanese were significantly larger (152.4 cm³ vs 82.5 cm³) than those of indigenous Japanese. With the accumulation of more cases, it is hoped that the relationship between the volume of the mammary gland and the presence of proliferative lesions can be determined.

Prostate Carcinoma

As with breast cancer, the age-adjusted incidence rate of prostate carcinoma is greater among the Japanese in Hawaii (13.9/100,000/yr) than in Japan (3.2/100,000/yr).¹ A collaborative study has been in progress between Dr. K. Akazaki of Aichi Cancer Center Research Institute, Nagoya, Japan, and Dr. G. Stemmermann of Kuakini Hospital, to examine the prostate glands of necropsy subjects among native and migrant Japanese males over 50 years old. They examined 239 prostates of native Japanese and 158 of Hawaii Japanese in an earlier report and found that the age-adjusted prevalences of latent cancer of the prostate did not differ significantly in the two groups.³⁴ However, in Hawaii Japanese, latent carcinoma tended to proliferate and invade; the age-adjusted prevalence of the proliferative type of latent carcinoma was significantly higher in the migrant group. This is shown in Table 7. Although the slides between Japan and Hawaii could not be read in a blind fashion because of their distinctive characteristics, the same precise diagnostic criteria were utilized. It is unlikely that bias could account for the degree of differences reported here. These findings further substantiate the importance of environmental factors in promoting the development of cancer.

GOALS

Many years will pass before the major goals of the JHCS program are realized. As sufficient numbers of large bowel, stomach, and prostate cancer cases develop among study participants, the relationship of these cancers to potential

risk factors identified in the study design can be determined in this prospective study.

The association of dietary factors with specific cancers is of much interest. Many investigators believe diet plays a major role in the development of various tumors, but it is obvious that dietary research presents formidable problems. Among these is the difficulty of detecting the presence of a dietary association with cancer, if dietary habits are relatively homogeneous in a population. The Hawaii Japanese appear to have a substantial variation in the Westernization of their food habits.³⁵ Consequently, we believe that the chances of detecting a dietary relationship are better in this heterogeneous population than in other more homogeneous ones. With this thought in mind, we are in the process of devising a simple 4-day diet record to supplement the diet-recall questionnaire. It is expected that the two methods of collecting dietary data will complement each other well.

Another major advantage of the JHCS program is that serum specimens from all study participants are being frozen for analysis at a later date. As informative tests are developed in the future, the sera from appropriate cases and controls can be analyzed for comparative studies. The potential returns from this resource are great.

Lastly, as more and more of the study participants are examined at autopsy, their findings can be correlated with potential risk factors identified during their examination in the program. This identification and utilization of definitive endpoints of disease derived from necropsy material in a well-defined population is one of the most important features of the JHCS program.

Acknowledgement

The authors wish to thank the study participants and their physicians for their invaluable assistance with this research project.

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The insurance will cover it!

We are hoist by our own petard!

You have a new house. You own it and it has considerable value (or more likely the bank owns it, and the bank figures the house is valuable, or it would not have given you the mortgage money). You must insure it against the very unlikely but always possible eventuality of fire. Your neighbors do the same with their houses. The insurance carrier has it all figured out in actuarial tables—that the likelihood of your house burning down is so small that it will accumulate a large fund from the premiums paid by you and your neighbors over the years. The fund will become so large, it can easily pay a “benefit” to cover the rare and occasional accidental fire. What’s more, the fund will, in the meanwhile, grow and grow as the money is invested for interest and dividends; provided, of course, that the investment is wisely made and the stock market behaves. Sure, there is a risk. Ten or a hundred houses may burn down all at once. Not very likely! The stock market may crash. Again, pooh-pooh! Both eventualities may occur in unison. Oh yes? Ha, ha!

But that is what has occurred—not in home fires, but in medical malpractice insurance.

It is happening in other fields of insurance as well. In the Social Security Administration—the FICA tax (Federal Insurance Contributions Act), mislabeled an insurance premium, has rapidly reached a point, despite its increase, where it will not be able to pay the claims against it. The same can be said for Unemployment Compensation Insurance, for TDI, and for auto casualty insurance. The accumulation of the premium dollars are neither up to meeting the demands of claims, meeting the effects of inflation, nor of withstanding the depression in investment values.

We have done it to ourselves. We have gone insurance mad.

The principle in insurance is that the larger the base of premiums paid, and the premium can be quite small, the less impact on the fund will the occasional, the rare claim, which is presumed to be reasonable, have on that fund. Many people will be paying in order that a few people may receive.

The equation has to be in delicate equilibrium. Insurance is workable **ONLY** if premiums are adequate to cover eventuality of claims. Earnings from investment of the fund is the “gravy” that helps the flow of profits. If claims surpass a certain level, then premium rates **MUST** go up. And if earnings drop too, and costs rise, and the profits evaporate when the premium rate increase meets the resistance of intolerance, who can blame the insurance company for quitting the field? Obviously, neither “pooling” nor legislative fiat can or should force insurance carriers to continue to provide coverage under these circumstances.

Of course it will help—in the malpractice field as well as in all other insurance fields—to try to reduce the outflow in claims. We, as a civilized society, really have to work at it, even to the extent of legislating curbs and limits to claims, to impose restrictions on lawyers and their clients, on judges and juries; work at it by imposing more stringent peer review within the ranks of the medical profession; work at it through education of the public. But we also need to look at insurance as a whole, to re-examine its basis.

In the field of medical care and our voluntary insurance system, it is the same: The premium we pay is geared to the claims benefits ratio. Most people cannot afford to buy an annuity type of life insurance—a policy that will pay you back so much a month after you reach a certain age. Both our Social Security program and the proposed National Health Insurance are some form of annuity programs. Why then do we think the government can afford to pay **ALL** of us an annuity? We are blind to the fact that the “insurance” we are asked to buy, even though our individual portion of the premium seems small, cannot possibly cover claims that each of us will make, sooner or later. We fail to see that the total premium, in fact, is huge in terms of contributions from employers and the government, passed on to us in costs and in taxes, and, big bite out of our take-home pay as it is, it still cannot buy this nation a policy big enough to satisfy all claims, unless the latter are drastically restricted.

We have also done something else to ourselves—by going the insurance route. Not only have we promoted the rise in number of claims for benefits of one sort or another—everyone feels himself entitled to a piece of the pie—but we have also

thereby inflated the values we are insuring. E.g., if a penniless motorist, whose car was not insured, is cited and held liable for damages, no one in his right mind would bother suing him. If a doctor, however, who may well have, but is invariably presumed to have, a million dollar malpractice policy, tackles a difficult surgical problem and the result comes out less than perfect, why, he is a set-up for a suit. It is the insurance presence that promotes this becoming-universal attitude; and even something far less as a nuisance settlement makes this "good hunting" for client and lawyer!

In the profession of medicine in particular, where it has reached a point that insurance is not even purchasable, and as regards insurance in general, we need to re-evaluate our concepts. Insurance is inflationary! John Q. Public needs to realize that *his* premium dollar is meant to pay someone else's claim—some person less fortunate than himself—and it is *not* meant to pay his own annuity as well.

We have been promoting voluntary health insurance, and other medically-related insurance too long and too vigorously. Maybe we need to go back to pay-as-you-go principles and promote Individual Responsibility.

J. I. FREDERICK REPPUN, M.D.



H. TOM THORSON

Malpractice Update—The Joint Underwriting Association (JUA) is progressing in the development of operating rules and regs. Included in the classes to be covered in the event of activation will be the Osteopaths and the Medical Doctors, as well as the acute care hospitals, Skilled Nursing Homes and the Intermediate Care facilities.

Underwriting standards will be subject to peer review input from the professional associations involved.

Legislation—A position paper from the HMA has been mailed to all members. Every member is urged to familiarize himself with the material so that when the chips are down and legislation actually in the hopper, each member can have some input to the legislators. At all costs we want to be united in order to have the maximum effect. If any member has a question relative to any stated policy, please take it up with HMA before adopting a different stance.

With about a hundred pounds of reference material, it is impossible to provide each member with all of it, but we are able to provide answers to specific questions.

The Feds—The AMA will testify before the House Ways and Means Committee on September 19, concerning the changes in the "reasonable charge" regulations under Medicare, and other related topics.

HMA Protests regulations requiring special explanation for use of general anesthetic in cataract surgery. There is no discernible reason for the requirement and all the literature belies the use of the regulation.

Suit Filed to block implementation of Maximum Allowable Cost (MAC) regulations by AMA. The suit contends that the Secretary of HEW exceeded his authority and that the regulations would deny quality care to poor and elderly patients under the Medicare and Medicaid programs.

Symposium on patient-doctor communications and the team approach was held on September 7. Symposium was jointly sponsored by the Hawaii Medical Association, the Hawaii Nurses Association and the Pharmaceutical Association. Nearly five hundred attended the meeting at the Ilikai. A separate program was held for the wives for the purpose of educating them up on what to do when the income producing member of the family is no longer around. The program was funded through a grant from Lederle Laboratories.

County Society Visitations by Dr. Winfred Lee, President; Dr. William Dang, President-Elect; Dr. Albert Chun-Hoon, Chairman, Malpractice Ad-hoc Committee; Dr. Chew Mung Lum, Chairman, Peer Review Committee; Mr. Tom Thorson, Executive Director, and Mr. David Weihaupt of the AMA. Meetings were held with the Hawaii County Society at Waimea on September 5, Kauai County on September 10, and Maui on September 11. The Honolulu County Society met on September 9.

Mutual Insurance Company—The corporation has been formed that will proceed with the investigation of the feasibility of the establishment of a mutual insurance company for the physicians and the hospitals of Hawaii to write their own malpractice insurance coverage. A lot of ground must be plowed before the final decision can be made and one step is being taken at a time.

AMA Meeting in Honolulu will begin November 30, and run to December 3. Those planning to attend and needing hotel rooms should contact Trade Wind Tours, Honolulu—phone 923-2071. All accommodations are being coordinated through one agency to avoid confusion.

HMA Meeting will be limited to meeting of the House of Delegates and some sporting events. There will be no scientific sessions this year because of the imminence of the AMA meeting. Detailed information will be sent as soon as the program is finalized. The dates are October 24-26, 1975 at the Mabel Smyth Building.

Training Program for Medical Directors of Skilled Nursing Homes will be held in Mabel Smyth Building, September 27-28. Registration fee of \$15 will be assessed. Meeting will be open without fee for the session on the afternoon of September 28, for those physicians wishing to attend the general session. Previous sessions on Saturday and on Sunday morning will be devoted to workshops.

General Useless Information—The HMA-HCMS office processed more than \$2,700,000 through its accounts in 1974.

Health Planners will get you if you don't watch out. Public Law 93-641, the health planning act contains the elements of complete control of medicine. The AMA will file an action protesting the law and questioning its constitutionality. In the meantime, the situation is confused in Hawaii as the Governor has asked for a waiver to avoid setting up a single Health Service Area so that there will be a single planning agency for the state. This is a very complex law and it appears that there will be very little professional input into the planning. The planning apparently will be done by those that have all the answers to questions that have not been asked.

Group Auto Insurance—About a year ago, your Association, working with Evans, Ochoa & Peters Insurance Agency, put together an automo-

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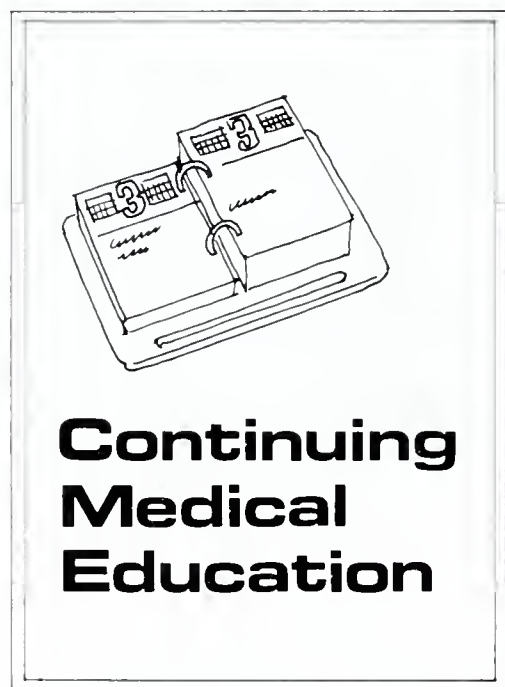
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bile group insurance program for the benefit of the members of HMA and their families. Many of you have taken advantage of this program and found that you were able to save from 15-30% on your auto insurance. To get information on this HMA program or obtain a form to be able to have a firm quote made, please call John Cavanah or Pam Lim of Evans, Ochoa & Peters at 531-0257, or drop a note to P.O. Box 201, Honolulu, Hawaii 96810.



ELIZABETH K. ANDERSON, M.D.

Understanding Category 1

Our monthly CME Calendar is published as a service to all physicians who are interested in attendance at formal courses which meet the requirements of Category 1 for the *AMA Physician's Recognition Award*. Two requirements must be met in order for an offering to be designated as Category 1:

- (1) The program must be sponsored or co-sponsored by an organization accredited for continuing medical education by the AMA Council on Medical Education.
- (2) It must be a planned program having sufficient scope and depth of coverage to form an educational unit that is planned, coordinated, administered and evaluated in terms of a specific educational objective.

It is important to understand that *it is institutions* which are accredited as sponsors of CME activities or programs, not the separate course or program. The Hawaii Medical Association has received approval from the AMA Council on Medical Education to sponsor as well as accredit those institutions or organizations who wish to become an accredited sponsor. To date the following institutions have been accredited: Children's, Kuakini, Kapiolani and Wilcox Hospitals and the Hawaii Thoracic Society. Applications are pending from Kaiser and Wahiawa Hospitals as well as the Hawaii Heart Association and American Cancer Society—Hawaii Division.

The *Supplement to JAMA* dated August 11, 1975 lists CME Courses for Physicians in the United States for the period from September 1975 to August 1976. There are included nearly 5,000 courses offered by 1,000 accredited institutions throughout the United States. A copy of the Supplement will remain on file in the CME Office at HMA.

1975 Physician's Recognition Award

The 1975 application forms have not yet arrived from the AMA. We will notify you as soon as they arrive.

CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS:

Ongoing

Kauaikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital

1. Tuesdays—CME Program, 1:00-2:00 p.m.
2. Grand Rounds, Wednesdays, 7:30-8:30 a.m.
3. Visiting Professor Programs (see Special Events)

Kuakini Hospital

1. Hematology Rounds, Monday, 1:00-2:00 p.m.
2. Gastroenterology, Tuesday, 8:00-9:00 a.m.
3. Oncology Conference, Thursday, 8:00-9:00 a.m.
4. Endocrine Conference, 2nd Wednesday each month, 1:00-2:00 p.m.
5. Medical Statistics, 3rd Tuesday each month, 1:00-2:00 p.m.

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

SPECIAL EVENTS

September 17-19 *Pediatric Post-Graduate Neurology Seminar* at the Princess Kaiulani Hotel. Highlighting the symposium will be Dr. Sidney Carter, Professor of Neurology at the College of Physicians and Surgeons, Columbia University, and Dr. Richard Schain, Professor of Neurology at the UCLA School of Medicine. Pre-registration at the Department of Pediatrics office of Children's Hospital. Registration fee.

September 21 *"Hypertension"* sponsored by Hawaii Heart Association and Hawaii Medical Association; at the Princess Kaiulani Hotel, Honolulu, 8:00 a.m.-3:30 p.m. Registration fee. Contact: Molly Austin, 538-7021.

September 27-28 The Medical Director in the Long Term Care Facility sponsored by Hawaii Medical Association through a grant from Region IX Department of HEW, Mabel Smyth Building, beginning at 1 p.m. on Saturday. Contact: Bess Chang, HMA Office, 536-7702.

September 28 Conference on Alcoholism, "New Diagnostic and Treatment Methods," sponsored by Hawaii Psychiatric Society, APA, HMA, Department of Health, University of Hawaii, Ala Moana Hotel. Registration fee. Contact: Bernice Coleman, M.D., phone 737-7811.

September 27-October 4 Workshops in Gynecologic Oncology, High Risk Pregnancy and Endocrinology-Inertility. UCSF at Maui. Contact: Malcolm Watts, M.D., School of Medicine, University of California, San Francisco 94143.

- September 30 Hawaii Thoracic Society annual Fireside Chat: Current Concepts in the Pathogenesis of Chronic Pulmonary Disease by Dr. W.G. Johanson, Jr. from University of Texas Health Science Center; Ala Moana Hotel, Vanda Room; 7:30 p.m. Will also present programs on neighbor islands: September 29, 8:00 a.m. at Wilcox Hospital; October 2, 7:00 a.m. at Maui Memorial Hospital; October 3, Noon, Hilo General Hospital; Honolulu hospital programs to be announced. Contact: Gary Houghtby, 537-5966.
- October 20-24 Pathology Review, USC at Mauna Kea Beach Hotel.
- November 29-December 5 American Medical Association, 29th Clinical Convention, Sheraton Waikiki, Honolulu. Contact: Frank A. Gray, AMA Convention, Services Department, 535 N. Dearborn St., Chicago, Illinois 60610.
- December 5-9 International College of Surgeons, U.S., Section Annual Meeting, Sheraton Waikiki, Honolulu. (A preliminary program is in the HMA office.) Contact: Marilyn Lento, PRC, International College of Surgeons, 1516 Lake Shore Drive, Chicago, Illinois 60610 or HMA (CME Office)
- December 5-11 Cleveland Academy of Medicine, Kona Surf/Sheraton Maui. Contact: Donald Mortimer, 10525 Carnegie Avenue, Cleveland, Ohio 44106.
- 1976**
- January 18 Medical Emergencies in the Elderly, presented by the American Geriatrics Association and the HMA, to be held at Straub Clinic, 8:30-4:30. Speaker: Thomas Criley, M.D. Contact: L. Clagett Beck, M.D., 523-2311.
- February 15-19 Sports Medicine for Primary Physician; Lihue, Kauai; Hawaii Medical Association EMS Program.
- 1978**
- April 1-7 Pan Pacific Surgical Conference, Hilton Hawaiian Village. Contact: Cesar B. deJesus, M.D., Pan Pacific Surgical Association, 236 Alexander Young Building, Honolulu, Hawaii 96813.

OUT OF STATE:

American College of Physicians; regional meetings as scheduled below:

- September 10-12 "Recent Advances in Infectious Disease" at Seattle, Washington
- September 22-24 "Psychiatry for the Internist" at Rochester, Minnesota
- September 22-24 Minnesota, Rochester (Mayo Clinic)
- September 22-26 California, Pasadena
- September 22-26 "Medical Oncology Review" at Vancouver, B.C., Canada
- September 26-27 Ohio, Mansfield
- September 26-28 Michigan, Gaylord
- September 29-October 2 "Cardiac Arrhythmias: Electrophysiology, Diagnosis, Treatment" at Philadelphia, Penn.
- October 2-4 California, Los Angeles (Beverly Hilton)

- October 2-4 "A New Look at the Hypertensions" at Oklahoma City, Oklahoma
- October 2-4 "Endocrinology and Metabolism: Current Perspectives" at Los Angeles, California
- October 4 Maryland, Baltimore (U of Maryland)
- October 8-10 Pennsylvania, Philadelphia
- October 8-10 "New Concepts in Basic and Applied Hematology" at Philadelphia, Penn.
- October 9-11 Oklahoma, Grove
- October 10-11 San Juan, Puerto Rico
- October 10-11 Chicago, Illinois (Drake Hotel)
- October 11 Rochester, Minnesota
- October 13-17 "Preventive Internal Medicine—The Internist's Role in the Prevention of Acute & Chronic Diseases" at Memphis, Tenn.
- October 16-18 "The Clinical Spectrum of Adult Heart Disease" at Albuquerque, New Mexico.
- October 17-18 Fargo, North Dakota (Kahler Hotel)
- October 20-23 "Postgraduate Course in Endocrinology and Metabolism" at Durham, North Carolina
- October 20-24 "Contemporary Internal Medicine" at New York, N.Y.
- October 27-31 "Internal Medicine: Review & Advances" at Sacramento, California
- November 2-3 "Liver Disease for the Internist—State of the Art 1975" at Chicago, Illinois
- December 8-12 "Fluid & Electrolyte Balance, Hypertension and Renal Disease" at Chicago, Illinois

For further information: American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

- October 1 "Advances in Management of Coronary Heart Disease" Symposium sponsored by St. Francis Hospital Heart Center & the American Heart Association Council on Clinical Cardiology; at St. Francis Hospital Conference Center in Roslyn, N.Y.; 8 hours credit; tuition: \$50. For more information: Continuing Medical Education Department St. Francis Hospital Roslyn, New York 11576
- October 26-30 Annual Assembly of the American College of Chest Physicians, Anaheim, California. Contact: Alfred Soffer, M.D., Executive Director, Am. Col. of Chest Physicians, 911 Busse Highway, Park Ridge, Illinois 60068
- November 3-6 60th Annual International Scientific Assembly of Interstate Postgraduate Medical Association; at New Orleans Marriott Hotel; 20 hours credit; fee: \$40 advance or \$60 at meeting. For more information: Dr. Alton Ochsner, Program Chairman Interstate Postgraduate Medical Assn. P.O. Box 1109 Madison, Wisconsin 53701
- December 4-5 "Phenomenology & Treatment of Depression" at Shamrock Hilton Hotel, Houston, Texas; 15½ hours credit; fee: \$150.00. For more information, contact: Office of Continuing Education Baylor College of Medicine Texas Medical Center Houston, Texas 77025



Hawaii Academy of Family Physicians' Newsletter

J. I. FREDERICK REPPUN, M.D.

NEW MEMBERS—Anne Warren, UHSM'78 has joined us as a Student Member. David K. Livingston MD is a new Active Member; he is in Family Practice at the Kaiser Ko'olau Clinic. We welcome them to our ranks.

NEWS OF MEMBERS—Howard Liljestrang MD has switched from Active Exempt to Active again. He is also a Fellow. "Never too old to practice, means never too old to learn" and so the AAFP abolished the Active Exempt category of membership, except for grandfathers. Don Hall MD has also become a Fellow and Active.

WE FINALLY MADE IT!!—Six (6) years after Hawaii became a state, the membership records division of AAFP finally put Hawaii where it belonged—after Georgia—in the monthly report. We had squawked and squawked because Hawaii was always listed at the tail end amongst the foreign countries. We even dragged Alaska up into the ranks with us!

CREDIT HOUR COURSES—you are reminded to subscribe to the HAWAII MEDICAL JOURNAL—if you are not a member of the triumvirate AMA—HMA—County Med Soc. Members receive the journal as a part of their membership. Non-members must subscribe separately. This Newsletter is published in the Journal, and the latter now has a good monthly listing of all credit courses coming up. For HAFP members:

Sunday 7 Sept all day LEDERLE Symposium—Category E
Sunday 21 Sept all day HAWAII HEART workshop on Hypertension—Cat P

Sunday 28 Sept all day conference on ALCOHOLISM—Cat E
Please remember that courses labeled Category I for the AMA's Physician's Recognition Award do not necessarily qualify for AAFP Cat P! The best of all will be the 27th Annual Scientific Assembly AAFP in Chicago 6-9 October.

Any of you planning to attend the Chicago meeting, if you plan to be in Chicago early, may want to qualify yourselves as Alternate Delegates. The House of Delegates meets at 08:30 Saturday 4 October in the Palmer House and the business of the Academy will occupy all day Saturday, Sunday afternoon and Monday morning. Officially certified delegates are Felix Lafferty and Fred Reppun. We are entitled to two alternates.

RVS CONVERSION FACTORS—compare yours with what the VA offers as of 10 July 74: Medicine 0.65, Surgery 7.50, Radiology 2.80 and Pathology 0.33, 1974, not 1975!

FAMILY PRACTICE RESIDENCIES—are already available in the military in Hawaii. Members will be interested to learn that Bob Worth MD is the Chairman of the new Department of Family Practice and Community Health at UHSM. Don Farrell MD has been appointed Program Director and Kaiser Hospital has been approved for six openings in July 1976 first and second year residencies in F.P. Three more will be added in 1977.

... a matter of undecipherable gibberish

The Principles of Medical Ethics of the American Medical Association number ten in all. They are intended as precepts of good conduct for those in the profession as the physician deals with his patient and his colleague:

- 1 He gives service to and obtains the confidence of his patient
- 2 He continues to educate himself
- 3 He uses only the scientific approach to problems
- 4 He is expected to review, and be reviewed by his peers critically
- 5 He is free to choose his patient; he is expected to serve in an emergency; he may not abandon his case, and he may not solicit patients
- 6 He is to avoid conflicts of interest
- 7 He may expect fee for service, and he may dispense drugs, etc.
- 8 He is expected to seek consultation from his colleagues
- 9 He is to defend to the death the confidences given him by his patient
- 10 He must show an interest in the public health

These are paraphrased for the sake of brevity. They are intra-professional guidelines, and not, as so many take for granted, rules of conduct on the part of the patient. They are broad. They have been bent and bowed to meet changing times, but as principles, they stand on their merits.

The time has come to add two more:

- 11 In communicating by telephone with a colleague about a patient, the *calling physician* should be on the line when the one called responds by picking up the phone.

There is nothing more discourteous than the act of the caller, the presumptuous act of a person who considers himself the more important of the two (although the caller is usually the one asking a favor), who asks his nurse or aide to do the calling. Once his victim is on the line, the caller can keep him waiting and fuming while the caller finishes the dressing in the other room, or finishes the conversation with his next patient.

Worse yet is the discourtesy of the lowly interne or resident in hospital who is "much too busy" to do his own phoning. The presumption that the Attending on the other end of the line could not possibly be as busy as the interne, is the height of derogation.

- 12 When one physician asks another for a transcript of the patient's record, as authorized by the patient, the transcript should be typewritten, clear, concise and it should contain all of the essential data needed by the requesting physician in the future management of the case. To charge the patient for this service is ethical.

There is rarely anything more likely to light a man's fuse than to receive a heavy envelope full of illegibly photocopied undecipherable handwriting, often in some form of shorthand no longer even recognizable to the author. Alas, this is the outcome of and the outpouring from the instant machines.

It has become a matter of cost; the saving of time means the saving of dollars. A photo-copied page costs five to ten cents. The smaller office units make copies that stink, fade or turn black with time. The larger units cost a great deal to amortize and to service.

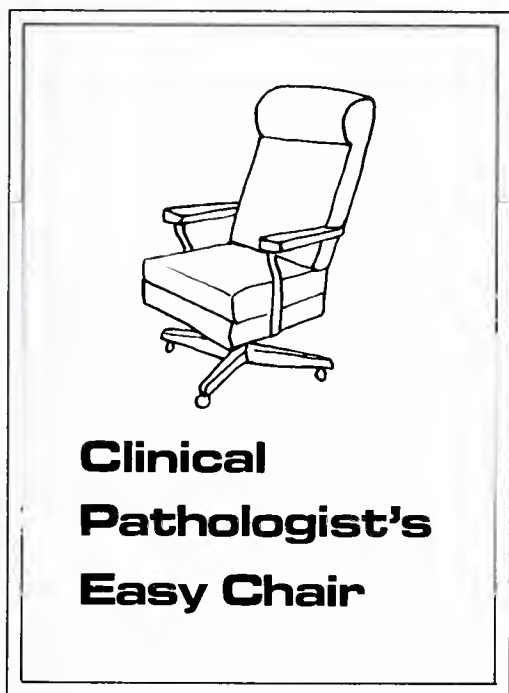
The type-written summary/transcript costs a great deal more, considering the physician's time who does the dictating, and the time spent by his secretary in the transcribing. Life insurance companies pay for this transcription—when they want it. The cost to them probably varies in direct proportion to the annoyance felt by the physician—which is not really a fair way of charging. Usually, the charge is by the line, or the page, or the hour. It is inherent in this request from a third party that the benefit in knowledge gained will accrue to that party; therefore, it is only right that the insurance company should pay.

In the instance in question, however, in which the patient is transferring his relationship to a second physician, it is

the patient who is doing the asking—via the second physician of course. It is in the patient's best interest that the important medical information in the hands of the previous physician be transmitted to the current treating physician. The charge, therefore, should be assessed against the patient by the requesting physician. The complying physician will feel better about charging a colleague, especially if he complies with a neat, typewritten summary, if he knows that the requesting physician will then pass the charge on to his patient (if he wishes to do so). The charge, of course, will show on the statement to the patient; it will also indicate to the patient that the request has been honored, and how long it took!

Shall we submit this as a resolution to the AMA when it meets here in Hawaii in November?

JIFR



By FRANCIS FUKUNAGA, M.D.

GLUCOSE TOLERANCE TEST

The interpretation of the glucose tolerance curve requires knowledge of the method of glucose analysis and the many clinical conditions that affect glucose metabolism. The earlier popular methods of analysis measured glucose in whole blood, while the present automated procedures determine glucose in serum or plasma. Glucose is uniformly distributed in the water phase of both plasma and cells, and since the red blood cell water content is lower, it follows that the glucose per unit volume of whole blood will be less than in plasma. Glucose levels are approximately 15% higher in serum than in whole blood and the normal range of the glucose tolerance curve must be adjusted accordingly. There are various criteria used: one is the Wilkerson point system, which

requires two or more points to diagnose diabetes mellitus:

TIME	SERUM GLUCOSE IN mg dl	POINT
Fasting	130 or more	1
1 hour	195 (200) or more	½
2 hours	140 or more	½
3 hours	130 or more	1

A committee report of the American Diabetic Association recommends a preparatory diet of 150 grams carbohydrate daily for three days. Two pieces of bread with each meal will usually satisfy this requirement. After a fast of about 12 hours, the patient is given 50 to 100 grams of glucose (40 grams per square meter or 1.75 grams per kg body weight). He should neither smoke nor drink coffee during the test. If a single blood glucose is used as a screening test, a one-hour postprandial level is considered the most meaningful. There is little justification for a lasting glucose determination for routine screening.

The glucose tolerance test shows considerable variability in some individuals and a single normal result will not rule out early diabetes mellitus. The variability tends to increase in people approaching abnormality. About 10 to 15% of glucose tolerance tests show an abnormal result at one, two, or three hours and when these patients are followed over a period of 10 years, about 50% will be clearly diabetic, especially if they are obese or have a positive family history. There is also a diurnal variation in glucose tolerance with less tolerance in the afternoon. Decreased tolerance is seen with decreased physical activity, various illnesses, following trauma, emotional stress, chronic renal disease, liver disease, obesity, pregnancy, age over 60 years, endocrinopathies including Cushing's syndrome, thyrotoxicosis, acromegaly, pheochromocytoma, and some drugs, such as corticosteroids, thiazides and oral contraceptives.

The intravenous glucose tolerance test is sometimes used to bypass the G.I. tract or to complete the test in one instead of three hours. Twenty-five grams of glucose, 50 ml of 50% solution, is given intravenously within four minutes, and the midpoint of injection is the "zero" time. Blood is then drawn every 10 minutes and the glucose values are plotted against time on a semilog graph paper. The steepness of the slope ("k" value) is determined for the time ("t") the glucose requires to decrease by 50%. Normal value for "k" is 1.13 or greater. The time (t) should be 60 minutes or less.

Plasma insulin levels may be of value in evaluating glucose tolerance. Plasma insulin normally peaks at 30 to 60 minutes and the second- plus third-hour value is less than 60 microunits. The peak is delayed to about 90 minutes in early diabetes and the second- plus third-hour value is over 100 microunits. The peak is delayed to 120 minutes and increased in adult-onset diabetes, while the curve will be flat in insulin-deficient diabetes. Study of insulin curves have shown that the classification of diabetes mellitus into juvenile and adult (maturity) onset types cannot be based upon the patient's age at onset. Insulin determination is used to determine the character of insulin response, obtain baseline data for rational classification, and evaluate therapy and prognosis.



BLEMISHES?

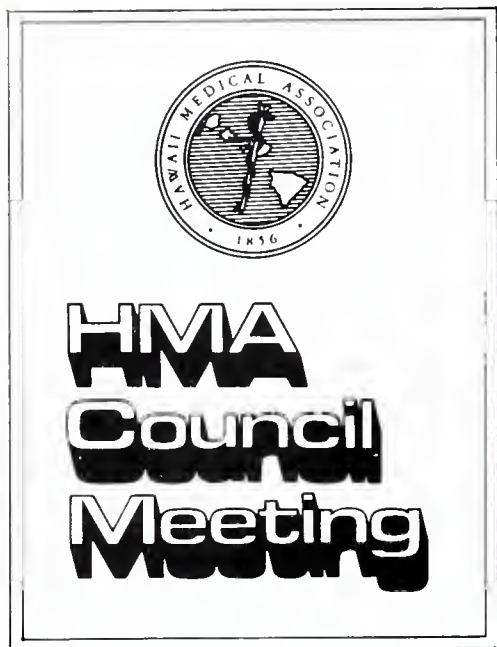
COVERMARK conceals all skin discolorations . . . birthmarks, brown & white patches, broken veins, tattoos, burns, scars, on any part of the body. COVERMARK is also unexcelled as an overall makeup . . . will not rub or flake off. Waterproof and Sunproof.

Lydia O'Leary

OF HAWAII

ALA MOANA CENTER—STREET LEVEL

PHONE 949-3288



Friday, May 9, 1975, 5:30 p.m.
Mabel Smyth Lanai

CALL TO ORDER

The meeting was called to order by President Winfred Y. Lee. Present were Drs. Grover H. Batten, Herbert Y.H. Chinn, George Goto, J.I.F. Reppun, John Edwards, Carl H. Lum, Ann B. Catts, Rowlin Lichter, Sakae Uehara, R.P. Wipperman (for Verne Adams), Peter Kim, Albert Chun-Hoon, and Marion Hanlon. Also present were Drs. Calvin C. J. Sia and Elisabeth K. Anderson and Mrs. Jackie Jones, Auxiliary President.

MINUTES

The minutes of the April 18, 1975 meeting were approved as circulated.

REPORT OF THE SECRETARY

The report of the secretary was approved as circulated.

REPORT OF THE TREASURER

The treasurer reported that the Finance Committee and Publications Committee had met to review the JOURNAL finances for the first quarter of the year. The JOURNAL is presently within budget. There were no new financial statements for Council review.

REPORT OF THE COMMITTEES AND COMMISSIONS

A. Bureau of Research and Planning: Dr. Robert Worth appeared before the Council to request endorsement of the Pacific Health Research Institute proposal for a Hawaii Health Services Research Center. A grant request was submitted on May 9 to the National Center for Health Services Research. A small local grant has been received to begin the research center and Dr. Worth asked that the Council nominate someone from HMA to serve on the board of directors. He also asked for a letter of support for the Federal grant. A copy of the entire grant was presented to the Council for future review.

ACTION:

It was moved and seconded that the HMA approve in principle a study or study group for a health services research center. It was voted to refer the entire matter with the grant for the perusal of the HMA Executive Committee and for their recommendation at the next Council meeting.

B. Medical Education and Peer Review: It was announced that the medical education programs of Kapiolani and Kuaikini Hospitals have been accredited by the Medical Education Committee and are now able to offer Category I credits

for the AMA Physician's Recognition Award. Nearly 100 persons have registered for the Seminar on Developing Accredited CME Programs which is scheduled for May 12-13 under the sponsorship of HMA, California Medical Association and Regional Medical Program of Hawaii. The Quality Assurance Program proposal submitted to RMP was given low priority for funding. Priority rankings for all projects will be finalized by the Regional Advisory Group of RMP on May 14.

C. Professional Liability: Dr. Dang and Mr. Thorson are presently attending a malpractice insurance meeting in Washington, D.C. A report from Dr. Pavel who attended an orthopedic meeting regarding malpractice was distributed to the Council as well as a copy of the recently enacted Indiana law. Dr. Lee announced that an ad hoc committee on malpractice, formed for the purpose of developing the position of the HMA with regard to medical malpractice legislation and other related matters, will be chaired by Dr. Chun-Hoon with members Drs. William Dang, John Lowrey, Alan Pavel, Fred Reppun, Chew Mung Lum, Ken McCollum, and Peter Kim (a representative from Hawaii County is to be appointed).

D. Internal Affairs: Mrs. Jones, retiring Auxiliary president, noted that the Auxiliary really would like to know in what way they might assist the Association. The Council asked the Auxiliary to assist them in selecting a gift of appreciation for the retiring president of the AMA Auxiliary, Mrs. Betty Liljestrand. A kukui nut lei as well as another gift of appreciation was approved. It was also voted to encourage committee chairmen to include members of the Auxiliary in committee deliberations.

E. Public Health: The Substance Abuse Committee recommends HMA support of an Alcohol Education Program to be held at the Ala Moana Hotel on September 28, 1975.

ACTION:

It was voted to support the program.

D. Interprofessional and Public Affairs: The winners of the HMA Awards for the 18th Hawaiian Science Fair were announced.

E. Legislation: The president reported a letter of support for a legislative bill sponsored by the Dental Society has been written. Several of the measures supported by the HMA are awaiting the Governor's signature.

F. Cancer Commission: The Commission approved a travel itinerary for Tumor Registry staff to collect data from the neighbor island hospitals. Dr. Burch has been replaced on the Cancer Commission by Dr. Audrey Mertz.

G. PSRO: The progress report for April was circulated for review. Dr. Lee noted that the Pacific PSRO is the first PSRO in the nation to nominate two non-M.D.s to the PSRO Board. It is expected that actual PSRO activities will not begin until March or April of 1976.

H. Medical Services: The Fee Survey Committee met recently with the insurance commissioner to discuss a complaint made by an HMA member regarding discriminatory practices of an insurance carrier. The Department of Regulatory Agencies will be asked to investigate the charges. The Workmen's Compensation Committee met with representatives of the Workmen's Compensation Division to discuss some particular medical procedures which are not listed in the RVS. The committee also discussed the need for a total rehabilitation plan. It was announced that Dr. Benjamin Lambiotte was appointed Medical Director for the Workmen's Comp Division.

I. Site Committee: After the last Council meeting, the representatives from Chaney, Inc. reviewed their proposal with the developer of the site proposed to the HMA and agreed to modify the proposal to provide more flexibility in the amount of floor space leased. Initially, one of the primary reasons for seeking new quarters was to consolidate the many operations under the HMA/HCMS umbrella. The Site Committee has since been informed that the BME as well as the EMS project would be opposed to such a move, thus the amount of space required would be reduced considerably. The proposal was reviewed in detail as well as

costs relating to moving and the various rental agreements presently in effect.

ACTION:

It was voted to disapprove the offer and to thank the representatives of Chaney, Inc. for their excellent presentation. There was one opposing vote. The Council also recommended that the Site Committee consider the expansion of the Mabel Smyth Building which was proposed several years ago.

OLD BUSINESS

AMA Resolutions: Two resolutions proposed for the AMA House of Delegates were submitted for Council action and instructions for the AMA delegate. The first resolution relates to compulsory enrollment in health insurance and asks the AMA House of Delegates to repudiate their endorsement of the principle of compulsory health insurance. It was voted to leave the Delegate unstructured on this resolution. The second resolution asks that the AMA review the status of the Medical Officers in American Samoa and the Trust Territory of the Pacific with a view to affording them professional recognition and that consideration be given to their inclusion as PSRO members. It was voted to support the resolution.

The Bylaws Committee was asked to consider the responsibilities of the AMA delegation regarding voting instructions by the HMA Council.

The Council also asked that the delegate consider voting in support of candidate Joe Boyle for the AMA Board of Trustees.

NEW BUSINESS

Correspondence from the AMA: There had been a considerable reduction in the staff in an attempt to stabilize the financial situation. It was also noted that the editor of JAMA, Dr. Robert Moser, had resigned effective May 31.

ADJOURNMENT

The meeting adjourned at 9:30 p.m. The next meeting will be scheduled for early June or July.

R. A. KENDRO FOR

R. VARIAN SLOAN, M.D.

**Friday, July 11, 1975, 5:30 p.m.
Mabel Smyth Lanai**

CALL TO ORDER

The meeting was called to order by President Winfred Y. Lee. Present were Drs. William Dang, R. Varian Sloan, Grover Batten, George Mills, Herbert Chinn, George Goto, J. I. F. Reppun, Arnold Siemsen, John Edwards, Ann Catts, Carl Lum, Rowlin Lichter, John Kim, Sakae Uehara, Verne Adams, Peter Kim, Albert Chun-Hoon, Marion Hanlon, Ruben Casile, and Douglas Bell II, Calvin Sia, William Iaconetti, Mrs. Alice Tucker and Mr. V. Thomas Rice.

MINUTES

The minutes of the May 9, 1975, meeting were approved as circulated.

REPORT OF THE SECRETARY

The report of the secretary was approved as circulated.

REPORT OF THE TREASURER

The financial statement for May 1975 was approved subject to audit.

REPORT OF THE AMA DELEGATE

A. Letter from Dr. Siemsen: The officers have referred to the Bylaws Committee a letter from Dr. Siemsen requesting a bylaws change be submitted to the House of Delegates repealing that portion of the bylaws requiring membership in the AMA. This request will be circulated to all county societies and will be the subject of the Honolulu County Medical Society September membership meeting. Neighbor island county societies were also urged to present this subject to their membership. A representative from the AMA will be invited to attend any scheduled society meetings to discuss the role of the AMA and answer any questions.

B. Report of the Delegate: Dr. Mills reported on the activities at the AMA Convention and the reorganization of the AMA commencing in 1974. He will also present a detailed report to the Honolulu County Medical Society.

REPORT OF THE COMMITTEES AND COMMISSIONS

A. Crippled Children Committee: Dr. Bintliff presented a report on the proposed plan for Health Services to the Developmentally Disabled and asked that Council approve the comments drafted by the Crippled Children Committee.

ACTION:

It was voted to forward the report of the Crippled Children Committee to the Director of Health.

B. Substance Abuse: Dr. Robert Latta represented the HMA at a conference on Alcoholism and will present a report to the Council at its next meeting. The HMA has been asked to submit nominees for the position of director of the newly created alcoholism and substance abuse division within the Department of Health. The recommendations of the Substance Abuse Committee will be forwarded.

C. Medical Education: It was reported that nearly 100 persons attended the CME conference on May 12-13. G.N. Wilcox Hospital received accreditation of their CME program on May 27. Kaiser Hospital was surveyed on July 8. There are also applications for survey pending from the Cancer Society and Wahiawa Hospital.

HIGUCHI INSURANCE AGENCY, INC.

536-6070 or 531-5436

HONOLULU COUNTY MEDICAL SOCIETY'S INSURANCE PROGRAM ADMINISTRATOR

**TERM LIFE INSURANCE
DISABILITY INCOME INSURANCE**

**MAJOR HOSPITAL INSURANCE
DEFENDANTS REIMBURSEMENT INSURANCE**

D. Ad Hoc Committee on Malpractice Insurance: Dr. Chun-Hoon presented a letter outlining the guidelines recommended by the Ad Hoc Committee on Malpractice to serve as policy guidelines for the HMA.

ACTION:

It was voted to approve the policy direction as set forth in the letter written by Dr. Chun-Hoon as the policy for the HMA.

Dr. Chun-Hoon asked the county society representatives to relay these policies to their respective societies and noted that the committee would be willing to discuss this further if desired. It was also agreed that the policies would be circulated to the entire membership as soon as they are refined somewhat.

The committee has also discussed the possibility of a membership survey regarding past experience in medical malpractice. The survey would be conducted in a strictly anonymous and confidential manner. At the present time, the only information available on incidence of medical malpractice cases is that which appears in one of the business newspapers and which appears only after a case has been filed. The committee would also be interested in knowing the incidence of cases, the cause of action, and the method of settlement.

ACTION:

The Council granted permission for a survey of the membership regarding past medical malpractice experience, asked that the information be obtained in a strictly anonymous manner except for the identification of specialty classification and asked that the questionnaire be subject to the approval of the Executive Committee.

A letter to all members regarding the formation of a mutual insurance company for medical malpractice insurance was discussed in detail. In order to investigate the marketing base and whether or not sufficient reserves are available, it is recommended that the HMA join with the Hospital Association to form a corporation capable of evaluating the feasibility of forming an insurance company.

ACTION:

It was voted to approve the creation of a corporation appropriate for the creation and/or management of a mutual insurance company.

E. Peer Review: The HMA Peer Review Committee has called for quarterly reports from all county societies regarding their peer review cases. Each county has also been asked to submit copies of their bylaws to be reviewed by HMA's attorney. Dr. Casile presented some of the areas of particular concern to Hawaii County and their peer review program. A delegation from HMA will meet with the Hawaii County Medical Society on this subject in September.

F. Internal Affairs: The Convention Committee presented their recommendations for a party for the California delegation during the AMA Clinical Session.

ACTION:

It was voted to authorize the Convention Committee and the Executive Committee to plan a party as outlined for the California delegation, the cost not to exceed \$1800.

G. Interprofessional and Public Affairs: The Public Affairs Committee is presently reviewing a patient education program utilizing tape recorded health messages available by telephone. This system is presently used on the mainland and has proven to be very popular.

ACTION:

It was voted to support the concept of TelMed as an HMA project in order to seek Federal and community

support for the inception of the project.

It was voted to investigate the feasibility of instituting TelMed and to look into the possibility of using Physician's Exchange personnel and space for the TelMed program.

A request from the Department of Sociology was received for support of a questionnaire on various ethnic group attitudes toward health care.

ACTION:

It was voted not to support the questionnaire.

H. Community Health Care Committee: The committee reviewed the request of the Waianae Coast Comprehensive Health Center for a certificate of need to build an additional outpatient facility. The committee recommends that the HMA not support the request of the Waianae Coast Comprehensive Health Center for approval of its application for a certificate of need to construct an additional building for an outpatient facility and that the existing space of the WCCHC is adequate for its current and anticipated needs, based on actual observation on more than one occasion by impartial physicians experienced in rural practice.

ACTION:

It was voted to support the recommendation and to forward the position to Comprehensive Health Planning.

The Community Health Committee also recommended that the HMA adopt the AMA's policy on community professional directories which states in part "that it is not unethical for a physician to list his name and practice in a directory for community use provided that such a listing be done on a non-discriminatory basis."

ACTION:

It was voted to approve the recommendation.

I. Health Facilities: The Health Facilities Committee asked that one of the functions of their committee be changed as follows: "Study the problems of intermediate care facilities, provide liaison with hospitals and other associations, establish liaison with the hospital association and chiefs of staff."

ACTION:

It was voted to approve the change in the function of the committee as recommended.

J. HMA Policy, re, HCG: Copies of the recent Federal Drug Administration position regarding the use of HCG in treatment of obesity as well as the AMA's position on this subject were reviewed in detail.

ACTION:

It was voted to adopt the position of the AMA on the use of HCG in treatment of obesity which states in part: "That the AMA (and HMA) adopt a strong policy in opposition to the use of human chorionic gonadotropin (HCG) in weight control programs and be it further resolved that the AMA (HMA) take the lead in developing a public education program to warn our citizens about the potential dangers of such a weight control program."

K. Medical Services: Dr. Chun-Hoon reported that the Fee Survey committee is presently reviewing the 1975 California RVS and will probably recommend to the HMA House of Delegates that a new publication be printed in 1976. The Committee also plans to survey the membership regarding the use of the RVS and the conversion factors most frequently used.

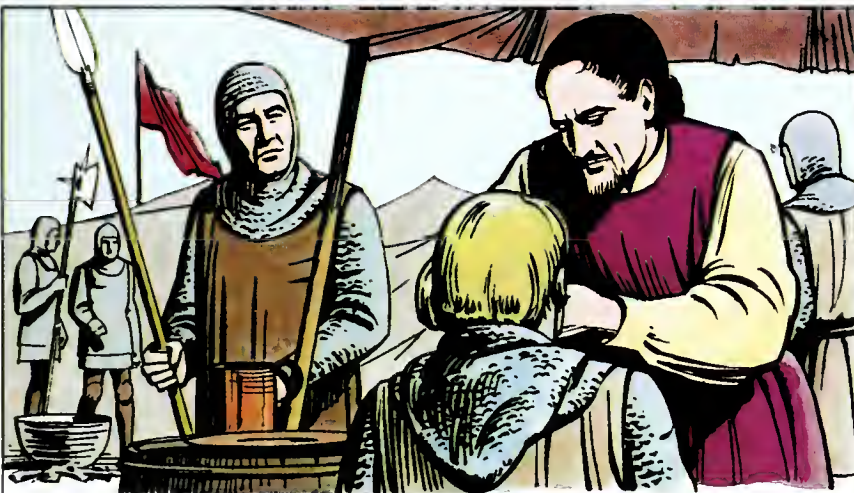
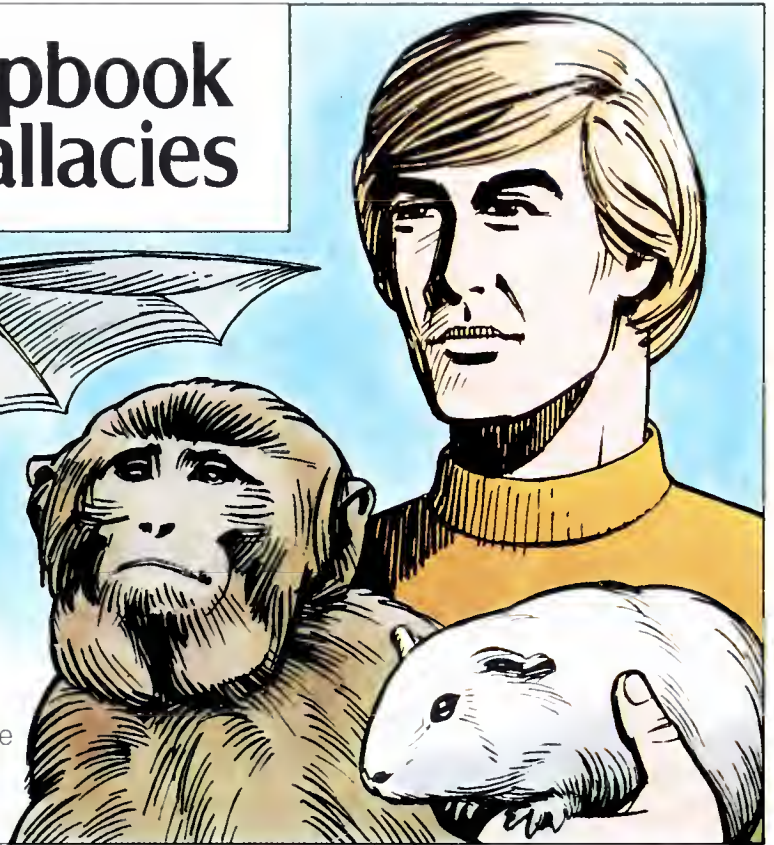
ACTION:

It was voted to support the recommendations of the committee.

The **ALLBEE with C** Scrapbook of Vitamin Facts & Fallacies

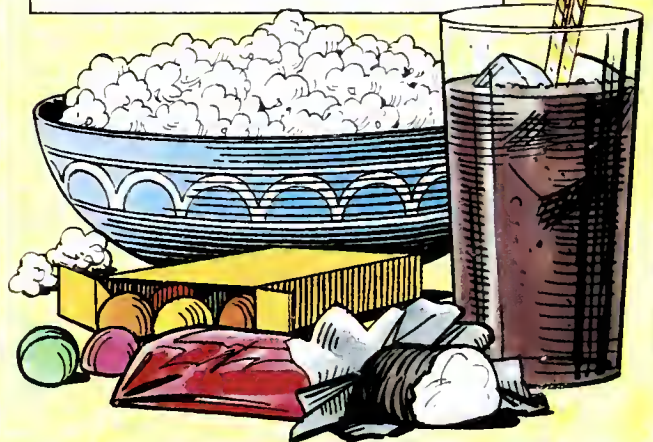


The Indian fruit-eating bat, almost all monkeys, man and the guinea pig are the only mammals whose bodies lack an enzyme needed to synthesize ascorbic acid from glucose! Hence they must obtain their vitamin C from exogenous sources.



De Joinville writing about a 13th century crusade reported that barber surgeons had to "cut away the dead flesh from the gums to enable people to masticate their food" The disease he described was probably scurvy.

A 1965 U.S.D.A. survey revealed that American diets were lower in vitamin C than they had been 10 years earlier!

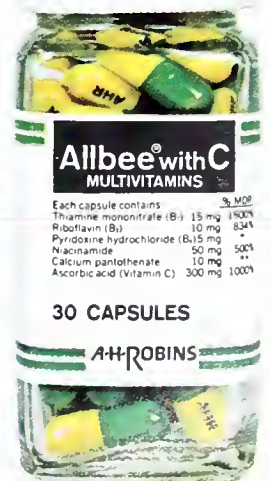


The outer leaves of cabbage and brussels sprouts contain more vitamin C than the heads. Yet, ironically, these are often trimmed away by the grocer to improve appearance and enhance sales appeal! Many housewives trim them even more before cooking!

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	each tablet, capsule or 5 cc. teaspoonful of elixir (23% alcohol)	each Donnatal No. 2	each Extentab
hyoscyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
atropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital	($\frac{1}{4}$ gr.) 16.2 mg.	($\frac{1}{2}$ gr.) 32.4 mg.	($\frac{3}{4}$ gr.) 48.6 mg.
(warning: may be habit forming)			

Brief summary. Adverse Reactions: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Contraindications: Glaucoma; renal or hepatic disease; obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); or hypersensitivity to any of the ingredients

A-H-ROBINS A. H. Robins Company, Richmond, Virginia 23220

L. Site: Inasmuch as the Council recently agreed that the administrative offices for the HMA/HCMS would remain in the Mabel Smyth for the time being, the staff was asked to consider the requirements for renovation and refurbishing the present offices. Two recommendations were presented: (1) That Council authorize the expenditure of \$1,000 to retain an architect to survey the offices and report the recommendations back to the Council, or (2) to proceed with the modifications outlined in the report to the Council.

ACTION:

It was voted to authorize the expenditure of up to \$1,000 to retain Architect Ossipoff contingent upon the approval of the HCMS Board of Governors. (Costs to be shared on a 60/40 basis).

OLD BUSINESS

A. HMA Roster: At the March 14, 1975 Council meeting, it was agreed to proceed with the publication of the 1975 Roster as proposed by Elson-Alexandre Company. The following recommendations were made regarding the order:

- (1) That 1500 copies of the Roster be ordered for distribution as follows: One free copy to each HMA member, 20 free copies to the Auxiliary, and a free copy to new members.
- (2) That additional copies be sold to HMA members for \$5.00 per copy and to non-members at \$10.00 per copy.
- (3) That only the following editorial pages be included: listing of officers, table of contents, principles of medical ethics, past presidents of the HMA, listing of hospitals, listing of specialty society officers, listing of membership by specialty, medical school and location.

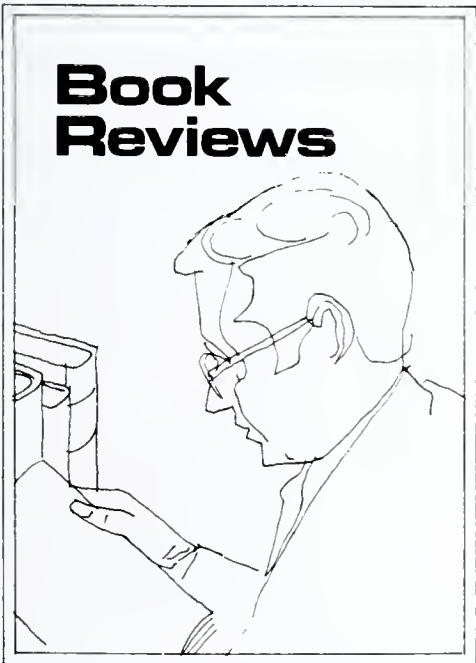
ACTION:

It was voted to approve the recommendations.

ADJOURNMENT

The meeting was adjourned at 11:30 p.m.

R. VARIAN SLOAN, M.D.
Secretary



Current Medical Diagnosis and Treatment

By Marcus A. Drupp, M.D. and Milton J. Chatton, M.D. (editors), 1044 pp.; \$13.50, Lange Medical Publications, Los Altos, 1975.

This is the biggest bargain in medical textbooks by a very wide margin indeed. Though it is specifically intended to be

a handbook of modern therapy, it could be used as a reference text, as well as just a ready-to-hand manual of current treatment. It is updated annually by a staff of authoritative consultants, and the price, in 1975, is so low it's hard to understand.

Every emergency room should have it handy; every generalist needs it on his desk; and virtually every specialist could make good use of his own special section just to see what an authority in his field thinks is advisable *this year* for this or that disorder.

It's highly recommended!

HARRY L. ARNOLD, JR., M.D.

Neuropsychiatry in World War II

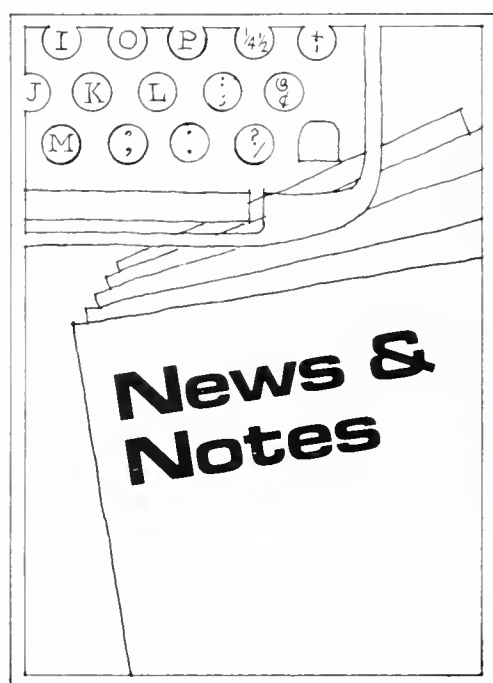
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THIS SECOND Volume records frustrations, failures, and successes as they occurred in the Army and Army Air Forces in overseas theaters. It describes similarities and differences in experiences and efforts in remote geographic areas and widely dispersed theaters of operations; and it includes chapters on American prisoners of war in Germany, Italy, and Japan. Throughout the volume, considerable emphasis is placed upon correlation of the nature, intensity, and duration of situational stress with the frequency and type of psychiatric breakdown.

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Hospitals May Require Insurance to be carried by physicians having staff privileges. A decision in a Louisiana court ruled that a private hospital may require that privileges be withdrawn if a physician does not produce evidence of adequate insurance. (Citation June 1, 1975, Vol. 31, No. 4.)



HENRY N. YOKOYAMA, M.D.

Sportsmen

We met with **Andy Morgan**, general chairman for Sporting Events for the coming 119th Annual Meeting of the HMA. The Skin Diving Tournament is limited to 8 participants (because of plane capacity) and will be held on Kalaupapa Oct 4 and 5 (Cost \$70.00). The Golf Tournament chaired by **Al Paraz** and assisted by **Bill Dang** et al. will be on Friday, Oct 24 at Mid Pac CC starting at 1 p.m. The Fishing Derby chaired by **Andy Morgan** will be on Sunday, Oct 12 and costs \$30.00. The Tennis Tournament chaired by **Virgil Jobe** will start on Sept 20th (cost \$10 with deadline Sept 19). The format will be the same as the last 2 years... Sportsman's Nite will be Friday night, Oct 21 at Mid Pac Country Club after the golf tournament and will be no-host cocktails followed by dinner (Steak and Prawns)... We also learned from **Bess Chang** that the Annual Banquet and installation of officers will be on Sunday, Oct 26 at the Hikai Hotel, Pacific Ballroom. There will be no HMA scientific meeting or exhibits this year because the AMA Clinical Sessions will start on Nov 30. Happy thought... perhaps we can solicit more prizes than in the past from the drug representatives, there being no HMA clinical sessions and booths to subsidize.

Of Trials and Tribulations

Pathologist **Ann Catts** got an emergency call during an HMA meeting... When she finally got through to the Queen's operator, she ruefully complained, "The operator says I have a patient in the morgue... And I'm not even on call..."

An 88-year old oriental man admitted for syncope had an EEG done as part of the diagnostic workup. He was radiant, "My head feels so light after you had all those needles stuck in my head." We decided not to explain that the procedure was diagnostic, not therapeutic...

Life in these Parts

A 71-year old oriental woman with HCVD and ASHD was described by her accompanying daughter as being increasingly forgetful of late. We started her on Hydergine with an ample supply of samples. When she returned for her next checkup, we inquired, "How did the new pills work?" "What new pills?" she said blankly...

There are 50 to 100 acupuncturists practicing here and the State licensing board is powerless because licensing requirements have not been established to date. In recent months, there has been an increase in their number because of the popularity of "ear stapling" for those wanting to lose weight or stop smoking... The chief investigator for the Consumer Protection office has been flooded with complaints from fatso's with ear staples to jiggle and says astutely, "Those walking around with staples in their ears might have been better off stapling their mouths..."

A visiting mainland podiatrist on Kauai claimed that people who go around barefoot or with sandals are ruining their feet... Retired orthoped **Steele Stewart** who had once reported on 8,500 bare feet says, "Going barefoot is about the healthiest way for going anywhere... When I was practicing, I didn't see a single case of a person who grew up here going barefoot with foot problems..." Kauai orthoped **Thomas Grollman** likewise feels that shoes are the cause of most foot disorders. "I haven't done a bunionectomy in two years... Shoes are very hard on feet... Most shoes are designed for cosmetics with their effect on feet placed second." When the visiting podiatrist attributed luau feet (splayed feet) to walking barefooted, Steele retorted this by pointing out that luau feet are hereditary and Tom commented that luau feet are a problem only when trying to put shoes on... Moreover, *Advertiser* writer Jan Ten Bruggen-cate points out that luau feet are better for body surfing without fins, for regular swimming, for stomping grapes to make wine and for better stability in a heavy wind or on a rocking boat...

Hawaii had a 16.2 infant death rate per 1,000 live births in 1974 as compared to the national rate of 16.5 and the Health Department Research Branch reports that mortality rates were 19 to 24 per 1,000 in the 1950's and 1960's. **Michael Light**, acting director of the PPC (Pediatric Pulmonary Center) at Children's Hospital, feels however that the rate can be lowered further by better training and better technological facilities...

It has been a local practice to allow visitors to air travel back to their home states within 2 to 3 weeks after a heart attack, but the stresses incurred at the airports and in flight have never been accurately determined. Cardiologist **Danelo Canite** heads a project which will monitor postinfarct patients for a 24-hour period during the patient's transit from the hospital to the airport, during flight and after his arrival on the mainland, using a 24-hour Avionics Holter Monitor. The project will set up guidelines for safe air travel of normal and cardiac populations and determine the effects of smoking, hypoxia, isometric activity, cabin pressurization, flying altitudes, oxygen supplement, etc....

The simple marble marker in Kipahulu, Maui says, "Charles A. Lindbergh. Born Michigan 1902. Died Maui 1974. ... if I take the wings of the morning, and dwell in the uttermost parts of the sea..." Since the funeral 8,000 names have been entered in the church registry compared to 1,400 names the year before... **Milton Howell** attended the flyer's death from cancer "not touched with extraordinary medical measures to prolong his survival" and described his last days in a JAMA article.

Miscellany

"How do you circumcise a whale?" "By sending out four skin divers." (As heard by **Jon Won** from **Grover Batten**)

The circus was in town and the elephant had escaped. The police desk sergeant received a frantic call from a woman who reported a strange large animal in her garden, pulling

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up her cabbages with its tail. "What's he doing with the cabbages?" the sergeant asked. "If I told you, you wouldn't believe me," she replied ... (As told by **Tom Thorson**)

Professional Moves

Homo Sapiens Medicus has seldom been this active. In August on Oahu alone, the following new physicians joined the medical community. GP's **Romeo Pineda**, and **George Monlux Jr.**, orthopod **Masao Takai** and cardiologist **Eugene Magnier** joined the Kaiser group at 1697 Ala Moana Blvd; urologist **Kendall Early** joined **Andy Morgan** at 263 Young Building, internist-nephrologist **Richard Shim** joined **Dudley Seto** at 23 So. Vineyard Blvd, internist **Gloria Madamba** joined the Straub Clinic, psychiatrist **Robert Collis** opened at Suite 1312, Ala Moana Building and GP **Glenn Stahl** joined the Windward Medical Center. On Maui, former JAMA editor **Robert Moser** rejoined the Maui Medical Group, pediatrician **Donna McCleary** joined the Kaiser program in Wailuku and GP's **Robert Bird** and **Rolland Erickson** took over the practice of **Al Burden** who retired in July. On Kauai, GP's **Larry Isakson** and **Robert Freeman** and pathologist **Rex Couch** joined the Kauai Medical Group Inc. On Hawaii, OB man **Santad Sirachainanta** and GP **Edwin Willett** joined the Kona Medical Associates.

We apologize for having missed internist **Frederick Fong's** announcement in July. Fred is locating at Queen Emma Building, Suite 308.

Tom Thorson's Corner

A Shakespearean repertory company was short on funds as it toured the Southwest and in order to save on printing expenses, it decided to put up the following sign:

Monday	"Wet"
Tuesday	"Dry"
Wednesday	"3 Inches"
Thursday	"6 Inches"
Friday	"9 Inches"
	9"—Taming of the Shrew
	6"—As You Like It
	3"—Much Ado About Nothing
	Dry—Twelfth Night
	Wet—Mid Summer Night's Dream
Legend:	

Little Alec wanted to know what it was all about and hid in the backseat of his brother's car as John drove out to lover's lane with his girl friend... He listened carefully when his brother John demanded, "You gonna make love or walk home?" The girl friend walked home... Next night Alec drive Suzy to the same lover's lane and said, "You gonna make love or walk home?" Suzy replied, "I wanna make love." "Gosh, what do I do now?"

A man enters a bar, plops his pet octopus on the counter and bets the bartender a drink that his octopus could play any instrument... The bartender pointed to the piano and the octopus played everything from Bach to Rock & Roll to Beethoven, and to the Blues... The man collected his drink and left. On successive days, he was back and he collected his hie drinks as the virtuoso octopus played the viola, the clarinet, the tuba, and the violin. Finally one day, the bartender beamed victoriously and said, "I've got him stumped this time," and produced a set of bagpipes. The octopus crawled all over the instrument, fingering each pipe with his tentacles. The man said reassuredly, "Don't worry, as soon as he finds out he can't make love to it, he'll play it..."

Elected, Appointed and Honored

Senator Hiram Fong announced that **George Mills** was ap-

pointed by **President Ford** to the National Advisory Committee for Juvenile Justice and Delinquency Prevention... **Governor George Ariyoshi** appointed **Al Chun Hoon** and **Tom Thorson** as directors of a 10 member board to develop the Hawaii Medical Malpractice Underwriting Plan established by the 1975 Legislature and which will provide malpractice coverage in the event coverage from commercial insurance companies becomes unavailable in Hawaii...

J. Alfred Burden was honored by the Maui Kiwanis Club when he retired after 36 years. Fellow physician and past president of the Kiwanians, **Jose Romero** recounted Al Burden's life and we were impressed that Al was born and raised in Tokyo of missionary stock and that he was a WWII intelligence and language officer. Al received the Silver Star for the Battle of Guadalcanal, the Bronze Star for the Battle of New Georgia and the Purple Heart (for a broken neck) when he was shot down in a plane distributing surrender leaflets. Besides a citation from Generalissimo Chiang Kai Shek, he also received the Legion of Merit for his tour of China under General Stillwell... As Jose says, "The thing that really makes Al Burden, is his humility and his dedication..." (We cannot agree more heartily).

Conference Notes

At a KCH noon meeting, psychiatrist **Byron Iliashof** lectured on biofeedback, which has been used for treatment of hypertension, cardiac arrhythmias, asthma, functional diarrhea, tension headaches, skin disorders, etc. Byron admits, "It is still not a panacea for everything." **Mary Glover**, with her left leg cast propped on a chair, asked, "Years ago, when I was an intern, either **Harry Arnold, Jr.** or **Sam Allison** said 'Never take away their neurodermatitis for they may become schizophrenic.' Does this still hold true?" Byron replied, "No, it's a common misconception even among our psychiatrists..."

Conference Pearls

- Kaplin lecturing on status asthmaticus says:
- Don't wait till the patient is half dead
- Don't use inhalors or nebulizers or IPPB
- Don't overuse epinephrine
- Don't kill patient with M.S., demerol or sedation
- Don't use O₂ routinely
- Don't use antihistamines...

Visiting Professor

Melvin Grumbach, pediatric professor at UCSF, was the visiting professor at Children's Hospital for one month in July and August. Medium statured, partially alopecic, bespectacled and immaculately suited, Melvin was a dynamic, organized and eloquent speaker who lectured to capacity crowds on puberty, its physiology, the control of its onset and disorders thereof during four Monday noon sessions... For what they are worth, we took the following notes therefrom:

Adolescence is one of the major neglected areas in pediatrics... Endocrinology is becoming simpler rather than complex... Growth is influenced by two factors: hormonal and genetic... The secular trend in maximum adult stature is ending because larger populations attain their genetic potential (ie, with more adequate nutrition)... Women have greater fat deposition and therefore greater potential for marathon running... Men have greater muscle strength because of their male sex hormones... Obese women have earlier menarches and are taller (Role of nutrition with menarche)... Body weight is correlated with menarche (The critical weight is 96 lbs or 47 Kgs)... The hypothalamus-pituitary-gonadal negative feedback mechanism is operative in the prepubertal child... There is decreasing sensitivity

AMA's Clinical Convention Flies to Hawaii !!

In addition to postgraduate courses, timely medical subjects will be offered each day in state-of-the-art lectures and symposia.

Advance Registration
AMA Clinical Convention
HONOLULU, HAWAII
November 30–December 5

SCIENTIFIC COURSES

Monday-Wednesday, Dec. 1-3/7:30-9:00 AM (4½ hour, 3-day course: \$45)

- 1. Dermatology for Non-Dermatologists
- 2. Evaluation of the Unconscious Patient
- 3. Hyperlipidemia
- 4. Infectious Diseases in Children
- 5. Management of Adolescent Problems
- 6. Newer Antibiotics
- 7. Newer Concepts of Family Planning
- 8. Office Management of Sexual Difficulties
- 9. Peripheral Vascular Disease—Diagnosis and Treatment
- 10. Pulmonary Function Tests and Blood Gases

Monday-Wednesday, Dec. 1-3 (Numbers 1-10)
1st Choice # ____; 2nd Choice # ____; 3rd Choice # ____

Monday-Wednesday, Dec. 1-3/10:30 AM-Noon (4½ hour, 3-day course: \$45)

- 11. Acid-Base, Fluid and Electrolyte Balance
- 12. Advanced Electrocardiography
- 13. Critical Patients—Critical Decisions
- 14. Normal and Abnormal Uterine Bleeding
- 15. Office Management of Anorectal Disorders
- 16. Office Practice of Gynecology
- 17. Physicians' Marriages
- 18. Special Problems of Child Abuse
- 19. Surgical Lesions of the Intestines—Diagnosis and Treatment
- 20. Treatment of Common Pediatric Allergies

Monday-Wednesday, Dec. 1-3 (Numbers 11-20)
1st Choice # ____; 2nd Choice # ____; 3rd Choice # ____

Thursday-Friday, Dec. 4-5/7:30-10:30 AM (6 hours for total course; 3 hours on Thursday, 3 hours on Friday:\$60)

- 21. Acid-Base, Fluid and Electrolyte Balance (repeat)
- 22. Basic Electrocardiography
- 23. Birth Defects and Clinical Genetics
- 24. Dermatology for Non-Dermatologists (repeat)
- 25. Fetal Monitoring
- 26. Ophthalmoscopy for the Non-Ophthalmologist
- 27. Pediatric Cardiology
- 28. Pitfalls of Emergency Room X-Rays
- 29. Office Endocrinology
- 30. Immunology—1976
- 31. The Uterine Pap Smear

Thursday-Friday, Dec. 4-5 (Numbers 21-31)
1st Choice # ____; 2nd Choice # ____; 3rd Choice # ____

Offered Both Monday & Tuesday, Dec. 1 & 2 /7:30 AM-Noon (4½-hour course: \$45)

- 32. Basic Life Support—Cardiopulmonary Resuscitation (Dec. 1)
- 33. Basic Life Support—Cardiopulmonary Resuscitation (Dec. 2)

Wednesday-Friday, Dec. 3-5/9:00 AM-Noon (9-hour course: \$90)

- 34. Advanced Life Support—Cardiopulmonary Resuscitation. (Prerequisite: Basic Life Support Course) (Dec. 3-5)

Courses of the AMA Committee on the Medical Aspects of Sports (Each a 3-hour course: \$30)
Monday, Dec. 1/7:30-9:00 AM & 10:30-Noon

- 35. The Physical Exam

Tuesday, Dec. 2/7:30-9:00 AM & 10:30-Noon

- 36. The Oriental Arts (Karate, Judo, Yoga)

Wednesday, Dec. 3/7:30-9:00 AM & 10:30-Noon

- 37. Emergency Care on the Field

Thursday, Dec. 4/7:30-10:30 AM

- 38. Wrestling
- 39. Aquatic Sports

Friday, Dec. 5/7:30-10:30 AM

- 40. Rehabilitation

Tuesday-Wednesday, Dec. 2-3/7:30-10:30 AM (6 hours for total course; 3 hours on Tuesday, 3 hours on Wednesday: \$60)
41. Writing for Scientific Journals

LUNCHEON ROUND TABLES
(Held in Hilton Hawaiian Village Long House Room, luncheon round tables are jointly sponsored by the AMA Auxiliary and AMA Council on Scientific Assembly. Cost: \$10.00 each.)
Tuesday, December 2 (12:15-1:45 PM) • Topic—Ancient Polynesian Medicine
Thursday, December 4 (12:15-1:45 PM) • Topic—Dehli Belly, Gypsy-Tummy, and Other Diseases of Travelers

General Registration

____ Non-member physicians: \$35	____ AMA members and their guests: no fee
____ Guests of non-members: \$10	____ Medical students, interns and residents: no fee
____ Foreign M.D.'s: no fee	

My remittance of \$ ____ is enclosed. Make check or money order payable to the American Medical Association. Payment must accompany registration.

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Name _____
(Each physician must register in his own name)

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Return this form today to AMA's Dept. of Membership Statistics, 535 N. Dearborn St., Chicago, IL 60610

of the gonadostat to the negative feedback effects of the sex steroids with puberty...

Male Puberty: Testicular growth: Ages 9 to 14; pubic hair: 9½ to 15; penis growth: 10½ to 15½; peak height velocity: 12 to 16; adult penis: 12½ to 17; adult: 13 to 17

Female Puberty: Breast bud: 11.2; onset pubic hair: 11.7; (Mean ages) peak height velocity: 12.1; menarche: 13.5; adult breast: 14.4; adult pubic hair: 15.3

Puberty restraining factors are CNS and LRF rather than the gonads and the pituitary... Delayed adolescence is due to lack of LRF for LH, FSH, testosterone and estradiol levels are normal... The differential diagnosis of delayed adolescence, includes chronic diseases (eg Sprue), hypothalamus-pituitary deficiency; and primary gonadal failure...

Miscellany

"Did you hear about the cannibal passing his mother-in-law in the jungle?" (Walter Young)

We found the following limerick in lou boyd's "Just Checking." "There was a young man of great gumption... 'mongst cannibals had the presumption... to go, but alas, he never came back... they said 'twas a case of consumption!"

Scientific item also from lou boyd's column: "Somewhere in the brain's computer mechanism is a link to the nervous control of the iris. The pupils enlarge 17% when an interesting object is identified. A woman viewing a picture of a mother and baby responds with maximum opening while a man barely responds. On the other hand, a man responds maximally when viewing pictures of a nude woman..."

Daffynitions

Intoxication: that physical state of feeling sophisticated without being able to pronounce it.

An attractive drunk is a cute alcoholic...

Oncology Dialogue

A 69-year old Japanese male with a two-year history of hequency, dysuria and nocturia developed an elevated acid phosphatase level. Cysto and perineal needle biopsy of his prostate revealed adenocarcinoma. TUR and orchiectomy were done. Pathologist **Grant Stemmerman** reported, "We have 5 cases of prostatic Ca in the house now..." Noting that a bone scan had not been included in the workup, immunologist **Ben Gordon** asked, "Shouldn't a bone scan be routine?" Heads nodded approbation... Stemmy stated, "The problem is how to stage." Urologist **Bill Shiraki** elucidated, "Every Center is doing it differently... We use staging for treatment, but staging is not as clear cut as 7 or 8 years ago... X-ray therapy is used as a curative procedure. It's a question whether estrogen should be given before or after symptoms start..." Radiotherapist **Carl Boyer** agreed, "Radiotherapy is used for cure, but estrogen works better... 5% of cases are amenable to radical surgery, but result in impotence. Radiotherapy does control even local metastases... It is true... There is no clear cut mode of treatment..." Stemmy added, "35% of all caucasian men over 70 have occult prostatic Ca... It's almost a normality." Bill suggested, "Someone recommends routine perineal biopsies." Stemmy replied, "I wouldn't want one... Someone may find it positive..."

Physicians Speak Up

Richard You, our peripatetic sportsman and AAU official reports from East Germany that ice cream is five cents and

beer a dime, but gasoline over \$5 per gallon...

Oh, where, oh where has my lil' ulcer gone? When **Albert Mendeloff** of Sinai Hospital reported on the puzzling decrease in ulcer cases on the mainland, *Advertiser* reporter Mary Cooke interviewed Kuakini pathologist **Grant Stemmerman**. Stemmy said, "It's awfully hard to get a handle on it... Ulcer is not a reportable disease unless it's a cause of death... The Japanese, by all odds, have the highest frequency of gastric ulcer in the world. In a study of Japanese men born here between 1900 and 1920, 4½% have had gastrectomy for ulcer, which is incredible. But over the past 10 years at Kuakini, where two thirds of the patients are Japanese, there's been a steady decline in both gastric and duodenal ulcer patients. Admission of such patients is about half what it was 10 years ago..." Stemmy offers as clues to the case of disappearing ulcers, the decreased use of cigarettes, the increased economic security and the decreased use of pickled or preserved foods. Rather than an increase in irritable colon and inflammatory diseases of the lower GI tract as on the mainland, Stemmy reports, "As gastric cancer disappears in local Japanese, cancer of the lower intestine is rapidly increasing... It has a reciprocal pattern and we can't say why..."

Parasitology specialists **Wayne McKinny** and **Wasim Siddiqui** warned that immigrants were bringing parasites into the State and that unless treated, parasites could run rampant through the general population. Wayne accused the Health Department Epidemiology Branch of being too lax about the parasite problem and described himself as a "voice crying out in the wilderness..." Wayne called for immediate parasite screening tests of all new school entries and for new immigrants, especially those from the Philippines, Samoa and Southeast Asia. **Ned Wiebenga**, state epidemiologist, however differs. "The whole thing sounds too inflammatory... It's the kind of thing that will result in a lot of heat and not enough light... We are aware that some of the immigrants are bringing in parasites, but they're not bringing in anything we don't already have here."

Wilmot Boone of Kealahakua got his dander up when **Senator Dan Inouye** criticized the attorneys, the insurance companies and "lambasted us of the medical profession for not policing each other—and suggested government surveillance if we don't do so..." The Senator expressed himself rather curiously like many who expect miracles from medicine, not realizing the variety of human weakness or failure. Already American medicine is of the highest order, worldwide, but there simply cannot be perfection, man himself being imperfect... Already we have endorsed a great deal of self-regulation, far more than any other profession. It is not usually the incompetent who suffers malpractice suits: it is by far more often the finely trained specialist. Are you suggesting that Big Brother can improve the best? It has happened before and has seriously hurt medical practice in other countries. Better let the government police the legal profession and the politicians. We physicians need far less of our 'government's... ponderous dictates' than lawinakers need our psychiatric examination and supervision; and I say that without humor..."

Bob Moser was back on Maui after resigning as editor of the JAMA "because of major philosophic differences with top AMA management." He considers "the Chicago venture a whole new discipline to learn and master. I wouldn't have traded the experience for anything in the world... But I'm really glad to be home... I plan to stay."

Miscellany

A Texan from Fort Worth was in a Broadway bar where he noticed a horse tied to the counter with a basketful of \$5 bills. Curious, he asked the bartender who explained that it was a contest to make the horse laugh and the entry fee was \$5... "I'd like to try," said the Texan and tossed a \$5 bill into the basket... He moseyed over to the horse and whispered into its ear... The horse responded with a great hearty neighing. The surprised bartender handed him

the basketful of money and he went away happy... A year later, the Texan was back in New York and entered the same bar. The same horse was there with a basketful of \$10 bills. He enquired and the bartender explained that it was now a contest to make the horse cry... So the Texan tosses in his entry fee and asks if he can take the horse out of the crowded bar for a minute... The bartender could see no harm and consented... The Texan led the horse out through the rotating door and returned shortly with the horse shedding great big tears. The bartender handed the Texan the basketful of money and asked, "What's your secret?" "Well, the first time, I whispered to the horse, 'I have one bigger than yours...'" He laughed... This time, I took him out, dropped my trousers and showed him..." (As told by **Tom Leineweber**)

Community News

The UofH Med School received 16 Federal grants worth \$1,000,000 and the School of Public Health 10 grants totaling \$766,343. Another six grants were received for cancer and related research worth \$350,000. The City and County of Honolulu received 3 grants totalling \$191,605 including \$310,735 for establishing and operating the emergency medical services system on Oahu, \$87,093 for training emergency medical technicians and \$93,777 for training mobile intensive care technicians...

Notes on 17th Annual Medical Arts Tournament (MidPac CC 8-7-75)

Superbly organized tournament with **Don Maruyama**, acting chairman and **Garth Morimoto**, **Ed Izawa** and **Art Salcedo** assisting... 84 entries... Wild Calcutta betting Monday noc at Garth Morimoto's... Poor **Nobu Nakasone**, our calcutta partner... Rumor spread by **Cool Wakai** that our game had jelled and **Dick Omura** bid \$115 on our team... Highest bid, \$180, was on **Dick Lam** and **Herman Mercado** while **Ed Izawa** and partner went for \$140. Desperate, we read Ben Hogan's "Fundamentals of Golf" till midnite and hit 2 bucketsful of balls before the game with a revised grip and swing... So we started down the first hole with 3 or 4 muffed shots... Such agony... **Frank Fukunaga**, our partner started badly the first nine with a buzzard on the first hole... kept mumbling he wasn't a tournament player... ended the first 9 with a lucky 43 and then proceeded to pitch and chip everything within 6 inches of the pin for the next 9 holes for a gross 79 and net 69... Lousy tournament player that he is, he won the jackpot, the calcutta and everything else in sight... Other calcutta winners included **Dick Ho** (net 71) and partner in 3rd place. In guest flight, **Frank Fukunaga** in 1st place, **Cool Wakai** with net 70 tied with two others for 4th place and **Dick Ho** tied with 6 others for 7th. Medical Arts Flight, **Nobu Nakasone** with a net 70 tied for 4th and **Ike Nadamoto** with net 72 tied for 6th place... Hi Lites: Volkswagen Dasher contributed by Path Lab and Airport VW for a hole-in-one on the 4th Hole... MC **Paul Tamura** announced that **Sidney Kosasa** (Thrifty Drugs) had suggested that the Dasher be given away as a door prize and read off the winning ticket number... 852-434... We looked again at our ticket stubs in hopeful disbelief till Paul, our jokster, announced that the number was really his own... **Frank Fukunaga** on our table commented that Sidney looked like he could use Preparation H... Our master wit and MC, Paul Tamura was at his best: "Ladies and Gentlemen—Welcome to the 17th Annual Medical Arts Golf Tournament... This is the first time **Dick Sakimoto** is not present... The word is that he is in Kona for the Billfish Tournament... and that his boat has caught the most Owama... Since we have no speeches from him, we can go

home within a short time... Now in Japan, when you finish playing golf, the workers all bow and say 'OTSUKARE SAMA DESHITA'... So let me say to all you golfers, 'OTSUKARE SAMA DESHITA.'" Indeed, we did feel tired after shooting so badly...

Hi Lites of Annual Kuakini Staff Party

Exquisite Japanese cuisine arranged by **Tom Fujiwara** since brother Larry owns Natsunoya Tea House... sashimi, oysters baked in the half shell, clam, shrimp tempura, sushi, roast chicken and roast duck, etc. washed down with generous portions of Chevas Regal, Royal Crown etc., etc. ... Physician of the Year award received by **David Sakuda** in behalf of **Edgar Childes** (who was not present)... **Yutaka Yoshida** with his gruff humor introduced the surgical house staff... **Mel Kaneshiro** likewise introduced the medical housestaff and explained a new two finger technique for pelvic exams (instead of the usual index and 3rd finger, he advocates a thumb-5th finger technique)... **Andy Morgan** sitting at his usual place in front of the stage was disappointed when the strippers did not come down to tease his blond nesses... The Gay Blades included a Prince Hanalei, Macy Williams, Michelle and a most attractive femininely endowed stripper (whom **George Suzuki**, our expert swears must be a feminizing testicular syndrome)... Nadine Bruce promised to perform her rendition of a stripper at next year's staff party... We missed the usual joke swapping contest by **Max Urata**, **Gary Glober**, **Al Shimamura**, **Ralph Cloward**, etc... but we did enjoy **Jack Ikeda's** rendition of "Banzai" done with such fervor...

Kaiser Medical Center News...

(Submitted by A.C. Ignacio)

The department chiefs of the Kaiser Medical Care Program are as follows:

Surgery: **Clifford Straehley**; Medicine: **John Kim**; Pediatrics: **Alexander Roth**; OB/GYN: **Paul McCallin**; Primary Care: **Donald Farrell**; Laboratory: **Alfred Scottolini**; Emergency Room: **Stephen Ugelow**; Koolau, Physician-in-Charge: **Victor Dizon**; Maui, Physician-in-Charge: **Neville Achong**.

On May 1, **Eugene McKeown** was ratified as acting Chief of Radiology and **Herbert Young** as Physician-in-Charge of Punawai Clinic. On June 12, **Alfred Anderson** was named Acting Chief of Anesthesiology and **William Cody**, Acting Chief of Psychiatry.

The University of Hawaii Integrated Medical Residency Program was started July 1... Presently 5 medical residents are at Kaiser Hospital... Also two surgical residents (one from Stanford and the other from the U of H Integrated Surgical Residency program), one pediatric resident from KCH, one OB/GYN resident from UCSF and one neurology resident from U of H Psychiatry Program are at Kaiser's... The Hospital Education Committee headed by **Clifford Straehley** include **Alfred Scottolini**, **John Kim**, **Ramon Sy**, **Richard Stevens**, **Richard Korsak**, **Yi-Chuah Ching**, **Azucena Ignacio** and **June Cole**.

Congratulations are in order for **Andre Choan** for becoming a fellow of the International College of Pediatrics; for **Paul McCallin** for being appointed to the Health and Community Services Council of Hawaii; for **Roy Sam** for becoming a founding member of the American Academy of Acupuncture, Inc. and for **Bill Harris** for setting a world distance record of 28 miles for hang gliding.

The following are new additions to the medical staff: **Alfred Anderson**, **William Cody**, **Abraham Goldstein**, **Anandom Hariharan**, **Martin Hoffman**, **Leonard Howard**, **Norman Ikemoto**, **Ken Kreisman**, **William Lucas**, **Eugene Magnier**, **George Monlux**, **Romeo Pineda**, **Richard Siegal**, **Donna McCleary** and **Masao Takai**. ■

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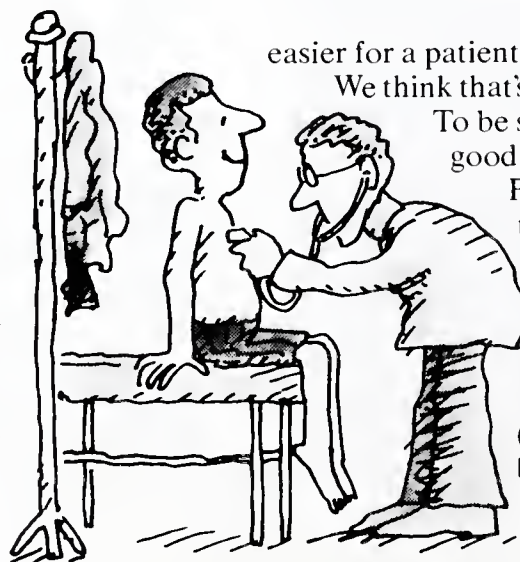
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Results (averages & ranges) can be seen in the Table at right. This study was conducted by Robert Kim, M.D., Straub Clinic and Hospital, Honolulu, Hawaii!

*G S Herbert Laboratories technical report #9



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Average ratings immediately after exposure	0.86 (0.80-1.00)	1.17 (1.00-1.30)	1.80 (1.00-2.00)	1.23 (0.60-1.80)
Average ratings 24 hours after exposure	1.13 (0.80-1.80)	2.66 (2.00-3.00)	2.78 (2.50-3.00)	2.66 (2.50-3.00)
Average ratings 48 hours after exposure	1.00 (0.50-1.80)	2.43 (2.20-2.70)	2.86 (2.50-3.00)	2.76 (2.70-2.80)

*The rating scale used for the study is as follows:
0=No Erythema □ 1=Mild Erythema
2=Moderate Erythema □ 3=Marked Erythema
4=Marked Erythema with Edema

Ranges appear in parenthesis

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May be the start of a better life for the epileptic

About nine out of ten epileptics suffer their first seizure in childhood.¹ Certain physical and psychic postseizure evidence—a badly bitten tongue, broken or dropped objects, amnesia, exhaustion—may suggest grand mal. Once the diagnosis of epilepsy has been established, *MYSOLINE (primidone)* may mean the start of a seizure-free life.

Early therapy for control of grand mal, focal and psychomotor epilepsy.


Used alone or as concomitant therapy, MYSOLINE may reduce the frequency and severity of major

motor seizures—or even eliminate them. Based on years of clinical success, MYSOLINE has earned the reputation of being an *excellent* drug for control of grand mal epilepsy.^{2,4} But its usefulness is not confined to this type alone: MYSOLINE has proved to be valuable for control of psychomotor^{2,3} and focal epilepsy⁵ as well.

Improves response to concomitant therapy.

When other anticonvulsants prove to be inadequate, adding MYSOLINE to the regimen can improve seizure control in grand mal and psy-





chomotor epilepsy. A double-blind comparative study⁶ shows that the combined use of phenobarbital, diphenylhydantoin, and MYSOLINE may have additive anticonvulsant effects without additive side effects.

Effective changeover therapy. Unsatisfactory performance or important side effects may force discontinuation of the patient's existing anticonvulsant therapy. For more effective control, MYSOLINE may be added to the patient's present regimen, then gradually substituted for the original medication. The changeover to MYSOLINE is frequently warranted when grand mal is refractory to phenobarbital, with or without diphenylhydantoin.⁷

Mysoline[®]

(primidone)

See last page of advertisement for prescribing information.

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Mysoline® (primidone)

May be the start of a better life for the epileptic

initial and maintenance therapy for grand mal, psychomotor and focal epilepsy

BRIEF SUMMARY

(For full prescribing information, see package circular.)

MYSOLINE® Brand of **PRIMIDONE**
Anticonvulsant

ACTIONS: MYSOLINE acts on the central nervous system to raise seizure threshold or alter seizure pattern. The mechanism(s) of action of anticonvulsant drugs is not known.

Primidone has anticonvulsant activity *per se*. In addition, its two metabolites possess anticonvulsant qualities. The major metabolite is phenylethylmalonamide (PEMA); the other is phenobarbital. In addition to its own anticonvulsant potential, PEMA potentiates phenobarbital.

INDICATIONS: MYSOLINE, either alone or used concomitantly with other anticonvulsants, is indicated in the control of grand mal, psychomotor, and focal epileptic seizures. It may control grand mal seizures refractory to other anticonvulsant therapy.

CONTRAINDICATIONS: Primidone is contraindicated in: 1) patients with porphyria and 2) patients who are hypersensitive to phenobarbital (see ACTIONS).

WARNINGS: The abrupt withdrawal of antiepileptic medication may precipitate status epilepticus.

The therapeutic efficacy of a dosage regimen takes several days before it can be assessed.

Use in pregnancy: Recent reports strongly suggest an association between the use of anticonvulsant drugs by women with epilepsy and an elevated incidence of birth defects in children born to these women. Reference has been made to primidone in several cases in which it was used in combination with other anticonvulsants; but its teratogenicity has not been conclusively demonstrated. The possibility exists that other factors, e.g., genetic factors or the epileptic condition, may contribute to the higher incidence of birth defects. The data also indicate that the great majority of mothers receiving anticonvulsant medication deliver normal infants.

Anticonvulsant drugs should not be discontinued in patients in whom the drug is administered to prevent major seizures because of the strong possibility of precipitating status epilepticus with attendant hypoxia and risk to both mother and the unborn child.

When the nature, frequency, and severity of the seizures do not pose a clear threat to the patient, good medical practice requires that the physician weigh the expected therapeutic benefit of anticonvulsant therapy against possible risk on an individual basis.

Neonatal hemorrhage, with a coagulation defect resembling vitamin K deficiency, has been described in newborns whose mothers were taking primidone and other anticonvulsants. Pregnant women under anticonvulsant therapy should receive prophylactic vitamin K₁ therapy for one month prior to, and during, delivery.

The physician should weigh all of the foregoing considerations when treating and counseling epileptic women of childbearing potential.

PRECAUTIONS: The total daily dosage should not exceed 2 Gm. Since MYSOLINE therapy generally extends over prolonged periods, a complete blood count and a sequential multiple analysis-12 (SMA-12) test should be made every six months.

In nursing mothers: There is evidence that in mothers treated with primidone, the drug appears in the milk in substantial quantities. Since tests for the presence of primidone in biological fluids are too complex to be carried out in the average clinical laboratory, it is suggested that the presence of undue somnolence and drowsiness in nursing newborns of MYSOLINE-treated mothers be taken as an indication that nursing should be discontinued.

ADVERSE REACTIONS: The most frequently occurring early side effects are ataxia and vertigo. These tend to disappear with continued therapy, or with reduction of initial dosage. Occasionally, the following have been reported: nausea, anorexia, vomiting, fatigue, hyperirritability, emotional disturbances, sexual impotency, diplopia, nystagmus, drowsiness, and morbilliform skin eruptions. Occasionally, persistent or severe side effects may necessitate withdrawal of the drug. Megaloblastic anemia may occur as a rare idiosyncrasy to MYSOLINE (primidone) and to other anticonvulsants. The anemia responds to folic acid, 15 mg. daily, without necessity of discontinuing medication.

DOSAGE AND ADMINISTRATION: The average adult dose is 0.75 to 1.5 Gm. per day. The initial dose is 250 mg. Increments of 250 mg. are added, usually at weekly intervals, to tolerance, or therapeutic effectiveness, up to daily doses not exceeding 2.0 Gm. A typical dosage schedule for the introduction of MYSOLINE is as follows:

Adults and Children Over 8 Years of Age

1st Week 250 mg. daily at bedtime	2nd Week 250 mg. b.i.d.
3rd Week 250 mg. t.i.d.	4th Week 250 mg. q.i.d.

In children under 8 years of age, maintenance levels are established by a similar schedule, but at one-half the adult dosage. It is best to begin with 125 mg., with gradual weekly increases of 125 mg. a day, to a daily total usually between 500 mg. and 750 mg.

In patients already receiving other anticonvulsants: MYSOLINE (primidone) should be gradually increased as dosage of the other drug(s) is maintained or gradually decreased. This regimen should be continued until satisfactory dosage level is achieved for combination, or the other medication is completely withdrawn. When therapy with this product alone is the objective, the transition should not be completed in less than two weeks.

MYSOLINE 50 mg. Tablet can be used to practical advantage when small fractional adjustments (upward or downward) may be required, as in the following circumstances:

- for initiation of combination therapy
- during "transfer" therapy
- for added protection in periods of stress or stressful situations that are likely to precipitate seizures (menstruation, allergic episodes, holidays, etc.)

HOW SUPPLIED: MYSOLINE Tablets—No. 430—Each tablet contains 250 mg. of primidone (scored), in bottles of 100 and 1,000. Also in unit dose package of 100. No. 431—Each tablet contains 50 mg. of primidone (scored), in bottles of 100 and 500. MYSOLINE Suspension—No. 3850—Each 5 cc. (teaspoonful) contains 250 mg. of primidone, in bottles of 8 fluidounces.

References: 1. Livingston, S., and Pruce, I.: *Pediatr. Ann.* 2:10 (Aug.) 1973. 2. Livingston, S., and Pruce, I. M.: *Drug Therapy for Epilepsy*, Springfield, Ill., Charles C Thomas, 1966, p. 23. 3. Scholl, M. L., in Conn, H. F.: *Current Therapy* 1973, Philadelphia, Saunders, 1973, pp. 675-7. 4. Metrick, S.: *C.M.D.* 37:49 (Jan.) 1970. 5. Forster, F. M.: *Med. Clin. North Am.* 47:1579 (Nov.) 1970. 6. White, P. T.: *Wis. Med. J.* 68:178 (Apr.) 1969. 7. Millichap, J. G.: *Drug Ther.* 1:15 (Oct.) 1971.

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New York, N. Y. 10017

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Each capsule contains 50 mg.
of Dyrenium® (brand of triamterene)
and 25 mg. of hydrochlorothiazide.



Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

*

WARNING

This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

*

*** Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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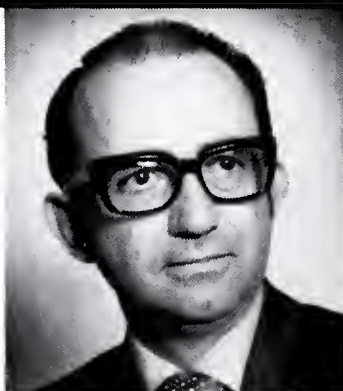
**Just once or twice daily for maintenance.
Hydrochlorothiazide to help keep
blood pressure down and triamterene
to help keep potassium levels up.**

Should a specially prepared package insert be made available to patients?

Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration



Dr. James H. Sammons
Executive Vice President
of the American
Medical Association



The idea of a so-called patient package insert has been around for a long time. Many physicians already use written instruction sheets to provide patients with information about the drugs they are taking. And some physicians give verbal instructions; but in too many instances these are what I call eye-glazing exercises. I have seen patients sit with glazed eyes listening to a rapid-fire lecture by a hurried physician who has 20 people out in his waiting room. These patients aren't given sufficient understanding and therefore do not follow instructions. So I think the idea of an official package insert for patients is a good one. Perhaps we should really think of this kind of information simply as an extension of drug labeling.

The benefits of patient involvement

Many physicians may not realize how frequently a patient obtains his drug information from Aunt Tillie or the next door neighbor. And this information is almost always bad or irrelevant to the case at hand. Furthermore, the incentive to go along with a prescribed program is slim if the only reading matter the patient receives, along with his prescription, is a bill.

As an educator I am impressed by the principle that the best way to get someone to do something is to involve him in the process. So the

I think there are advantages as well as some real disadvantages in a patient package insert. When you begin to use semi-medical or medical terms to describe complications or possible sequelae of disease or treatment, you may frighten the patient—particularly since the more highly sophisticated patient is not the one who is going to read the insert. The patient who will read it is the one most susceptible to fright and confusion by the language.

On the positive side, a package insert will probably give the patient better insight into why he is being treated the way he is, and it may give the physician a little bit more time. But it does not remove from the physician the need or obligation to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should be warned of the possibility of serious side reactions—to know what the real dangers are. But it doesn't do a bit of good to indicate that a patient on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that fright engendered by the insert may possibly outweigh the potential good.

OCTOBER, 1975
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Hawaii Medical Journal

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Both often



- Predominant psychoneurotic anxiety

- Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor

neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive dis-

orders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anti-convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or

two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al*: *Dis Nerv Syst* 30:675-679, Oct 1969.
2. Hollister LE, *et al*: *Arch Gen Psychiatry* 24:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics* 11:438-441, Sept-Oct 1970.

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of child-bearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle



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in psychoneurotic
anxiety states
with associated
depressive symptoms



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Colin C. Cameron Colin C. Cameron
Chairman and President, Kapalua Land Company, Ltd.
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Maui, Hawaii 96732.

Or call: Maui, 808-877-3882;
Oahu, 808-531-4550.



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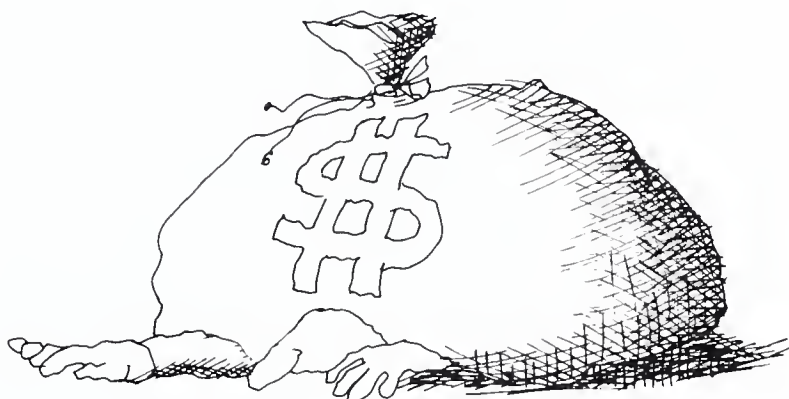
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For long-term control of hypertension*

Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

* WARNING

This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium fre-

quently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy

patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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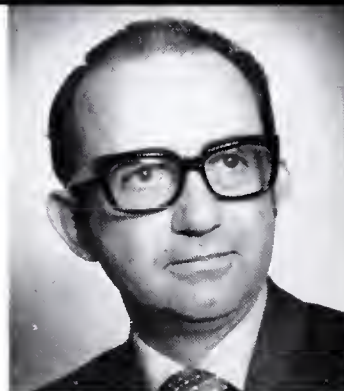
Just once or twice daily for maintenance.
Hydrochlorothiazide to help keep
blood pressure down and triamterene
to help keep potassium levels up.

Should a specially prepared package insert be made available to patients?

Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration



Dr. James H. Sammons
Executive Vice President
of the American
Medical Association



The idea of a so-called patient package insert has been around for a long time. Many physicians already use written instruction sheets to provide patients with information about the drugs they are taking. And some physicians give verbal instructions; but in too many instances these are what I call eye-glazing exercises. I have seen patients sit with glazed eyes listening to a rapid-fire lecture by a hurried physician who has 20 people out in his waiting room. These patients aren't given sufficient understanding and therefore do not follow instructions. So I think the idea of an official package insert for patients is a good one. Perhaps we should really think of this kind of information simply as an extension of drug labeling.

The benefits of patient involvement

Many physicians may not realize how frequently a patient obtains his drug information from Aunt Tillie or the next door neighbor. And this information is almost always bad or irrelevant to the case at hand. Furthermore, the incentive to go along with a prescribed program is slim if the only reading matter the patient receives, along with his prescription, is a bill.

As an educator I am impressed by the principle that the best way to get someone to do something is to involve him in the process. So the

I think there are advantages as well as some real disadvantages in a patient package insert. When you begin to use semi-medical or medical terms to describe complications or possible sequelae of disease or treatment, you may frighten the patient—particularly since the more highly sophisticated patient is not the one who is going to read the insert. The patient who will read it is the one most susceptible to fright and confusion by the language.

On the positive side, a package insert will probably give the patient better insight into why he is being treated the way he is, and it may give the physician a little bit more time. But it does not remove from the physician the need or obligation to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should be warned of the possibility of serious side reactions—to know what the real dangers are. But it doesn't do a bit of good to indicate that a patient on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that fright engendered by the insert may possibly outweigh the potential good.

Opinion
&
Dialogue

main purpose of drug information or the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is

no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a pa-

tient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

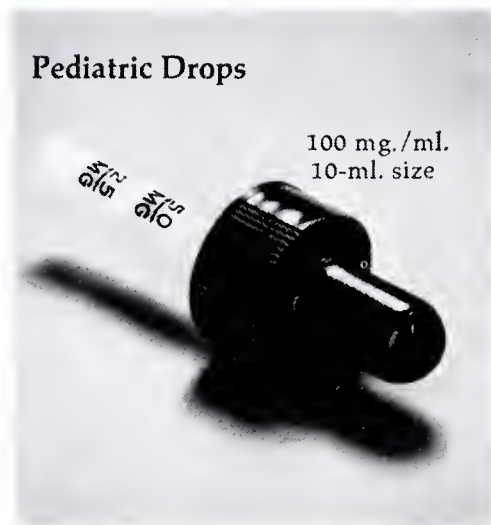
I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

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Clinical Cytogenetics In Hawaii— An Introduction To Chromosome Abnormalities

DAVID T. ARAKAKI, D.Sc.,* *Honolulu*

● *A brief discussion of the two principal forms of chromosomal errors is presented. Nondisjunction leads to the classical triplet state of the chromosomes. This type of error is associated with advanced maternal age and occurs sporadically. Translocations, on the other hand, are transmitted by a carrier parent which results in the recurrence of the chromosomal abnormality in the children. A few examples of these and other forms of chromosomal aberrations are illustrated.*

The genes which determine all inherited characteristics of humans reside on the 46 chromosomes. Alterations in chromosome number or structure can occur before or after fertilization, resulting in duplication or deficiencies of the genes. One of the main contributions which genetics has made to the field of medicine has been the classification and better understanding of a number of chromosomal anomalies¹. In children with non-specific congenital malformation and mental retardation, the applications of the banding techniques for chromosome identification is responsible for the recent discoveries of trisomies and partial trisomies, primarily of the C-group chromosomes^{3, 6, 8}. It is now clearly established that gross chromosomal abnormalities underlie several major syndromes which occur in man and that previously undetectable subtle changes in chromosome structure are the cause of many less well defined developmental anomalies.

One of the first congenital syndromes to be found to be associated with a chromosome defect was mongolism (Down's syndrome)¹¹. Within a short period of time, the sex chromosome anomalies^{5, 9} and trisomies for chromosomes

13¹² and 18⁴ were discovered in live births, while other trisomies were demonstrated in abortuses obtained from spontaneous abortions^{2, 7}. Down's syndrome is the result of a trisomy for chromosome 21, i.e., having three instead of two chromosomes 21. The trisomy results from the fertilization of an ovum involved in nondisjunction. Nondisjunction, which occurs sporadically and is associated with advanced maternal age, is the failure of homologous chromosomes to separate in the reduction division that formed the ovum from which the child developed.

Translocation

Not all cases of trisomies are the result of nondisjunction. For example, about one in 50 Down's syndrome children are the result of another genetic error called translocation. In these instances, the initial chromosome aberration occurs in one of the parents. One of the pairs of chromosome 21 becomes attached to another chromosome, most commonly to a D chromosome or to either chromosome 21 or 22. The translocation is generated early in gametogenesis, resulting in an individual with 45 chromosomes and who is phenotypically normal. All the genetic material is present, although its location had been changed or "translocated". This type of individual is known as a translocation carrier (Figure 1).

When the translocation chromosome and its normal homologue segregates at meiosis, three kinds of gametes are produced. When fertilization occurs, theoretically, a karyotypically normal offspring, a carrier offspring, and Down's syndrome will be produced, respectively. In actuality, depending on the sex of the carrier and the type of translocation involved, the expected risk of transmitting the rearranged chromosome to an offspring varies considerably from the theoretical expectations. Only in the case of

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FIG. 1.—Karyotype of a translocation carrier with a chromosome number of 45. The “46th” chromosome is attached to one of the other chromosomes without loss or gain of genetic material. Thus the karyotype is in a balanced condition and the carrier is physically and mentally normal.



translocation between homologous chromosomes, such as a 21/21 translocation, are we able to predict that 100% of the children will be affected. Unlike nondisjunction, abnormalities from translocation are found in younger parents.

FIG. 2.—A composite karyotype showing some of the types of chromosome abnormalities found in man. a) ring chromosome; b) short arm deletion (partial monosomy of the Cri-du-chat syndrome); c) reciprocal translocation (exchange of the long arms between chromosomes 8 and 17); d) inversion (pericentric); e) non-reciprocal translocation (without exchange of chromatin material); f) isochromosome (long arm of the X chromosome leading to Turner's syndrome); g) long arm deletion (partial monosomy); h) Robertsonian centric fusion (fusion of chromosome 13 and 14 by their centromeres); i) partial trisomy (chromosome 18); j) classical trisomy (trisomy 21).

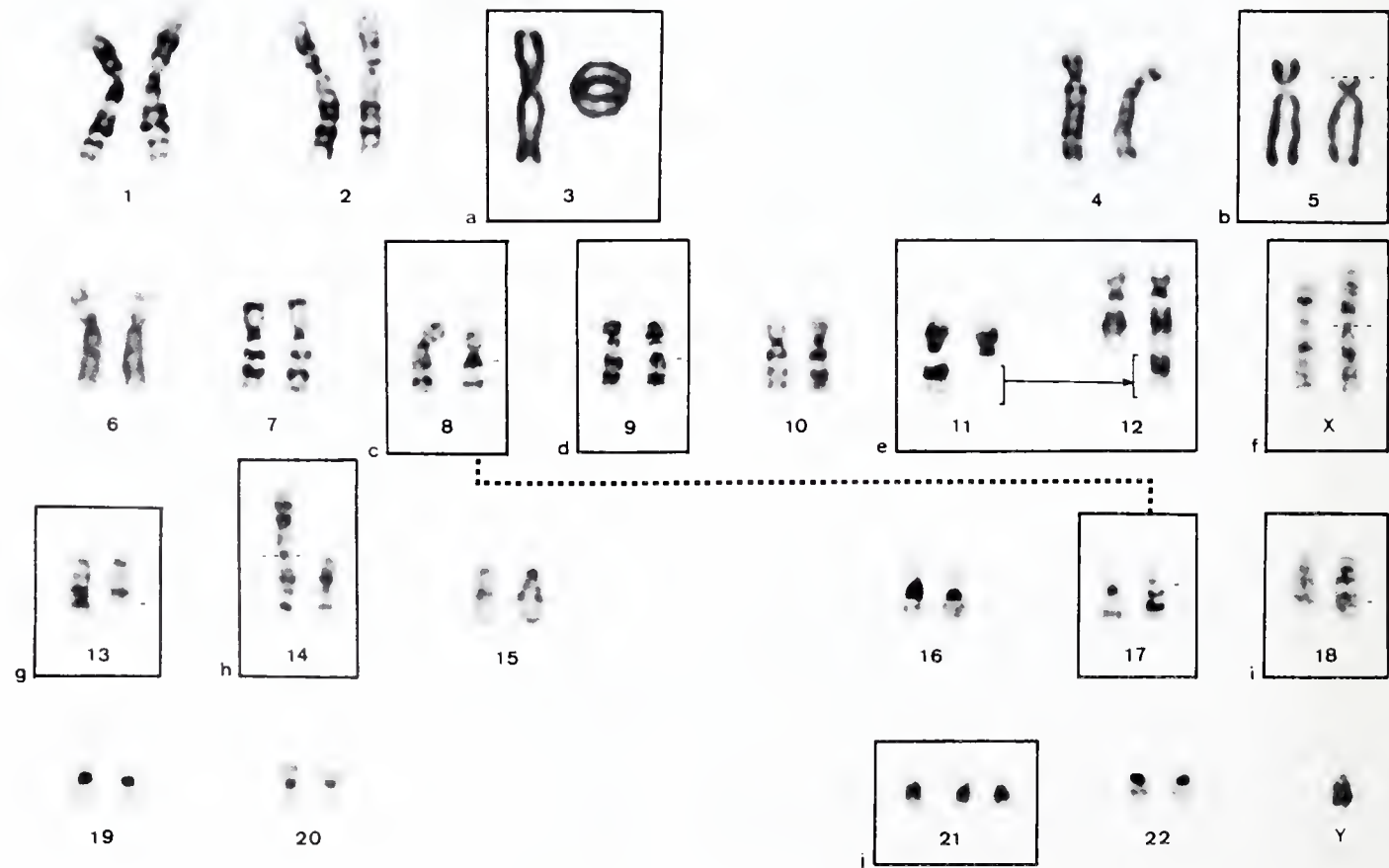


TABLE I.—Classification of Common Chromosome Abnormalities

Entity	Chromosome number	Karyotype*	Approximate incidence at birth
1. Down's syndrome			
Mongolism, Trisomy 21)	47	47, XY, +21 47, XX, +21	1:650
2. Turner's syndrome (XO)	45	45, X	1:2,000 females
3. Klinefelter's syndrome (XXY)	47	47, XXY	1:500 males
4. Edwards syndrome (Trisomy 18)	47	47, XY, +18 47, XX, +18	1:4,500
5. Patau's syndrome (Trisomy 13)	47	47, XY, +13 47, XX, +13	1:14,500
6. XYY syndrome	47	47, XYY	1:500
7. XXX syndrome	47	47, XXX	1:1,000
8. Cri-du-chat syndrome	46	46, XY, 5p-	1:45,000

*Designation according to the recommendations of the Paris Conference on the standardization of karyotype nomenclature.

The number of newly discovered translocation-related congenital defects is increasing rapidly due to the use of banding techniques for identifying previously undetected aberrations^{10, 13, 14, 15}. Translocation may soon replace

nondisjunction as the major cause of chromosomal anomalies.

Human chromosome disorders (Figure 2) include trisomies, monosomies (as in the XO Turner's syndrome), translocations, isochromosomes, ring chromosomes, deletions, inversions, partial trisomies or partial monosomies, multiple nondisjunctions, and mosaicism (mixed populations of chromosome constitutions). A list of common chromosome abnormalities, their chro-

mosome numbers, karyotype description and incidence is presented in Table I.

Unfortunately, there are no known cures for chromosome defects. Chromosome analysis, however, has made possible early diagnosis of the condition and the detection of the carrier in certain important situations. Knowledge of these defects and their associated medical problems have enabled clinicians to provide more effective genetic counseling.

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Arguments against Minimal Treatment

Carcinoma of the Breast, a Pan-Organ Disease

EUGENE M. EDYNAK, M.D., Honolulu

● Crile's outspoken advocacy¹ of minimal treatment of breast cancer has generated a great controversy over the appropriate treatment of this disease. Women's rights advocates have inappropriately become involved by attempting to dictate treatment which often runs counter to that recommended by the physician. This controversy has had some beneficial effect in that the surgeon today is reappraising the "standard" approaches to the treatment of primary breast cancer. This reappraisal, regardless of the ultimate outcome, has long been overdue

From the University of Hawaii School of Medicine
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and will surely lead to improved care of the patient with breast cancer.

Proponents of minimal surgery for breast cancer have ignored or failed to consider the overwhelming evidence that breast cancer is not a unifocal disease, but rather a multicentric malignancy, involving not only the clinically affected breast but in many cases the contralateral breast. Clinical reports from centers treating large numbers of patients with primary breast cancer, evidence from the pathology laboratory, and finally immunologic data offer irrefutable evidence of the multifocal nature of, and pan-organ involvement by, breast cancer. It is the

purpose of this summary to review this evidence supporting the contention that breast cancer is a pan-organ disease.

Histologic Evidence

Since the early work of Cheattle², Muir³, and Willis⁴, numerous reports have appeared in the literature describing the multifocal nature of breast carcinoma and the accompanying widespread microscopic changes of ductal atypia found throughout the breast. Qualheim and Gall studied histologic sections of 157 mastectomies by two parallel full-length blocks of tissue.⁵ They reported finding multiple foci of cancer in at least 54% of specimens. Of the multiple foci, 17% were limited to the one quadrant with clinically apparent disease, while in 37% of breasts, multiple tumor foci, histologically unconnected to the lesion presenting clinically, were found. Benfield, Jacobson, and Warner found such multicentric cancers in over 88% of 44 mastectomies in patients with lobular carcinoma *in situ*.⁶ Gallagher and Martin studied whole organ sections of excised breasts and found in 75%, additional foci of noninfiltrating carcinoma or borderline ductal atypia. In 50% there were multiple foci of frankly invasive carcinoma.⁷ More recently Fisher and co-workers, doing a very limited study and excluding lesions occurring in the same quadrant of the dominant mass, reported multicentric carcinomas in at least 13.4% of mastectomy specimens.

Clinical Evidence

The usually reported incidence of metachronous (delayed) cancer of the opposite breast ranges from 3.2% to 10%.^{9, 10, 11, 12} Robbins and Burke noted that of those patients with multiple cancers in one breast, one in five eventually developed cancer of the opposite breast.¹³ Urban reported finding cancer in 20% of 159 "blind" mirror image biopsies of the contralateral breast.¹⁴ As anticipated, the greatest incidence of bilaterality was noted in patients with lobular carcinoma. In a highly selected study, Hutter, Snyder and co-workers found that in patients with lobular carcinoma of the breast, approximately 64% showed eventual bilateral involvement, 43% having simultaneous involvement of the opposite breast.¹⁵ In a number of instances, Urban has noted multiple foci of frankly invasive carcinoma while performing a second mastectomy for "blind" biopsy findings of *in situ* carcinoma.¹⁶

Recurrence in Minimal Treatment

Peters reported a 65% five-year survival rate following quadrant excision and radiation. However, he admitted to a local recurrence rate of 15%.¹⁷ Atkins reported a five-year survival simi-

lar to those obtained by radical mastectomy and radiation, but only in patients who had clinically negative axillary lymph nodes. However, he observed considerably lower survival rates with quadrant excision and radiation in the presence of clinically positive axillary nodes, when compared with survival rates obtained with radical mastectomy and radiation for Stage II disease.¹⁸

Unfortunately the determination of the pathologic significance of clinically palpable axillary nodes is unreliable and inconsistent; some reports suggest only a 40-60% rate of accuracy prior to biopsy. Fifty percent of patients with clinically negative axillary nodes will have histologically positive nodes, while 25% of clinically positive nodes will be histologically negative.^{19, 20}

Rissanen reported on a prospective study of 2,400 selected patients, including 415 with Stage I lesions treated by local excision and radiation. Although five- and ten-year survival rates for these patients were nearly identical to rates achieved with a classical radical mastectomy and radiotherapy, the local recurrence rate was 25.8%. Rissanen reported no adverse effect on ten-year survival rates with local recurrence.^{21, 22} This observation has not, however, been substantiated by other investigators.

One of the great fallacies of authors citing survival statistics in support of minimal treatment appears to be the reliance on five-year survival data as opposed to ten-year survival. The current trend among major cancer writers is to look to ten- or even twenty-year survival. Atkins' report exemplifies this pitfall perfectly: whereas local excision and radiotherapy matched the five-year rate of survival after radical mastectomy for carcinoma of the breast, radical mastectomy produced significantly better ten-year survival rates in Stage II carcinoma.

Immunologic Evidence

In 1965 Loisillier *et al* demonstrated a nuclear antigen associated with a lacto-transferrin complex found in breast cancer tissue. This breast cancer "associated" antigen was also found to a lesser degree in the surrounding "normal" breast tissue.²³ In 1970, Taylor and Odili, using complement fixation, described a similar nuclear antigen in breast carcinoma, also found to a lesser degree in the adjacent normal breast tissue.²⁴

Finally, in 1971, Edynak and co-workers described a fetal antigen, the gamma FP-2, which was interpreted as a product of a primed cell with malignant or near malignant physiology. This particular antigen, was not demonstrated in either normal breast tissue nor in specimens from diseased but non-malignant breasts. However, this antigen was found both in malignant breast tissue and in tissue histologically free of

tumor at distances as far as 12 cm from the primary tumor. In addition, it was detected in the contralateral breast. Additional studies appeared to rule out the possibility of tumor breakdown and diffusion of antigen to the surrounding adjacent tissue.²⁵ Thus, all the available evidence points to antigenic changes *throughout* the breast in malignant breast disease.

Discussion

Histologic, immunologic, and clinical data appear to be overwhelming in support of evidence of carcinoma of the breast as a pan-organ disease. Why the multicentricity of breast carcinoma and the biopsy-proven bi-laterality of disease do not lead to early development of recurrent or new breast tumors in 100% of cases remains so far unanswered.

One explanation, in part, appears to be duration of followup. Carcinomas of the second breast sometimes present as late as 20-30 years after the initial mastectomy. The observed incidence of recurrent breast carcinoma (metachronous), involving the contralateral breast, ranges from 3-10%. However, as has been demonstrated by Hutter and Snyder, as many as 45-65% of patients with lobular carcinoma do have involvement of the opposite breast. In patients with intraductal infiltrating duct carcinoma the incidence of bilaterality is approximately 15-20%.

Whether hormonal patterns, immunologic host defense^{26, 27, 28} or some as yet undetermined system holds these remaining tumors of the opposite breast in check is unclear. However, in light of the evidence presented here, it would appear that treatment restricted to that

small area of the breast bearing the clinically apparent tumor would be grossly inadequate.

It may be that the ideal treatment for carcinoma of the breast, be it surgery alone or in combination with other treatment modalities, has not yet been standardized. This is particularly brought to mind by preliminary data reported recently by Prosnitz at the Yale University School of Medicine. Prosnitz and associates treated 30 patients with Stage I and II infiltrating duct carcinoma with radiotherapy alone.²⁹ The followup ranged from one to ten years, with 26 patients alive and well. Three of the 30 patients died of unrelated medical problems. Their data support the premise that, regardless of the modality, treatment to be effective in eradicating the multifocal areas of malignant disease should encompass an area greater than that of tumor-bearing breast.

Although the recommendation of the treatment of primary breast cancer is beyond the scope of this paper, points to be retained are (1) breast cancer is a pan-organ disease, with multicentric foci of infiltrating carcinoma involving the primary breast at least 50% of the time, and (2) cancer involves the contralateral breast in from 15% to 65% of cases. The primary treating physician must be aware that breast cancer is a systemic disease and should tailor his approach accordingly. Treatment protocols must be designed to treat the entire breast presenting with the clinical tumor.

Conversely, the treating physician must be aware of and prepared to accept the consequences when multiple foci of infiltrating carcinoma will be left behind with less than comprehensive treatment of the entire breast.

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29. Prosnitz LR: Personal communication.



H. TOM THORSON

One More Time—HEW has withdrawn a regulation requiring special reports if a general anesthetic is used in cataract surgery. HMA protested the rule, submitting documentation prepared by the Eye, Ear, Nose and Throat Society. A letter from AMA Legal Counsel and another from Aetna acknowledged the rescinding of the rule.

Airport Advertising—ruled illegal by Consumer Protector. Clinics in Japan have been advertising with illuminated signs at the airport for a variety of services. The signs have been held to be illegal and ordered removed.

On Again—We reported in August that the JCAH would not be reviewing hospitals in Hawaii during the last quarter of 1975. We have now been advised that ten of the hospitals will be reviewed during the period of October-December 1975.

Federal Register of September 10 made the official announcement that utilization review regulations for Medicare and Medicaid were withdrawn and would be reformulated. When rewritten, HEW will publish as "proposed" rules and opportunity for comment will be given.

AMA Continues Surveillance of FDA proposed rules regarding both drugs and devices or appliances.

AMA announces pilot program for improvement of health care in jails. Six states will be selected to take leadership in the implementing of improved health services. HMA has filed its letter of intent, expressing a wish to be considered as one of the six selected. Funding is made

by the Law Enforcement Assistance Administration of the Department of Justice.

National Insurance company being formed by AMA called American Medical Assurance Company for the purpose of assisting state associations in working out of the difficult excess insurance market. As this will take some doing and take time, HMA is proceeding with the exploration of other avenues.

Joint Underwriting rules and regs will be subject to first public hearing October 31, at 9:00 AM in Board Room, second floor of Kamamalu Building, 1010 Richards Street. Testimony should be submitted five days before the hearing in five copies.

Honolulu County Medical Society will hold its delegate caucus on October 21, in preparation for the HMA Annual Meeting. All delegates and alternates along with the Board of Governors should attend.

HMA Annual Meeting, October 25-26, will consider commission reports and recommendations as well as a number of resolutions. The most controversial resolution probably will have to do with the amendment proposed for the bylaws repealing the unified membership provision of the bylaws.

AMA Clinical Session scientific program published in September issue of this journal. The House of Delegates of AMA will meet in the Sheraton Waikiki as Follows:

SUNDAY	November 30	10:00 AM—Opening session House of Delegates
MONDAY	December 1	8:30/9:30 AM-5:00 PM Reference Committees
Tuesday	December 2	10:00 AM-6:00 PM House of Delegates
Wednesday	December 3	8:30 AM-1:00 PM House of Delegates

HMA members are urged to attend as many of the sessions as possible—especially some of the reference committee hearings.

HMA membership approaches 1000. If we reach the 1001 mark by the end of December HMA will have another AMA delegate in 1976. We will have, that is, if the House of Delegates of AMA does not exceed 250. This is a big "if", but quite probable. At present writing our qualifying membership is 994—now—if nobody does anything like dying or moving away—well, in any event we can still be a member of the Aces-Deuces.

National Health Insurance proposals revolve around three basic different concepts—

1. Comprehensive coverage under insured plans as at present with the government picking up a part of the tab based on income. To be paid out of general revenues. A number of bills are pending under this principle.
2. Kennedy-Corman plan is similar to the British system of National Health Service. Care to be provided through a national health service agency with a fixed annual budget. Funding would be through taxes on employment for half the cost and general revenues for the rest.
3. Catastrophic benefit plan where benefits would begin after certain health care expenses were met otherwise. Cost of the program to be met through Social Security taxes and benefits handled through the SSA.

General Practice Offices For Sale—Former office of Dr. Sanford Katsuki is available—contact Nancy Baird, Bishop Trust Co., 536-3771. Office is located at 1519 S. King Street.

Beautiful medical office, fully equipped, busy practice, prime location—Kailua. Lease reasonable. For further details call 261-6009.

Equipment—Almost new Castle Model 7 Speedclave for office use. Price \$295. Call Peter Yap, M.D., 949-6809.

Available For Free—For use by public service organizations—

One Bovie electrical surgical unit, model 03.

One Raytheon diathermy unit.

Call or write Dr. James Mayer, P.O. Box 3060, Kailua Kona, Hawaii 96740.

Positions Open—School of Public Health wants physician to serve as head of Maternal and Child Health Program. MD plus MPH required with two years in education. Apply to Mrs. Lorraine Stringfellow, School of Public Health, 1960 East-West Road, Honolulu 96822.

Physician with prime interest in Emergency Medicine. Practice to be in St. Francis Hospital. U. of H. affiliation with teaching program. Contact Dr. D.C. Ostman—phone 524-2100—Ext 387.

Associate Professor Department of Tropical Medicine and Microbiology at School of Medicine. Ph.D. or equivalent in microbial or cellular immunology required—teaching and research. Apply to Dr. Wasim A. Siddiqui, 3675 Kilauea Avenue, Honolulu 96816—phone 734-0221—Ext 240.

Faculty position, part-time, Dept. of Surgery, School of Medicine, (and Director, Surgical Education, St. Francis Hospital). Required

Board qualified or certified cardio-thoracic and general surgeon. Send curriculum vitae to Dr. Thomas J. Whelan, Jr., Harkness Pavilion Room 200, 1301 Punchbowl Street, Honolulu 96813.

Dr. Ronald Hattis would like to have locum tenens from October 21 thru October 28 on Kauai at Hanapepe. Call Dr. Hattis on Kauai 335-5121.

Available Positions: ASSOCIATE AND ASSISTANT PROFESSOR, RADIATION THERAPY—UH School of Medicine. MD required with Board Certification in Radiology or Radiation Therapy—teaching and research. Contact—Ruth James, UH School of Medicine. Closing date October 31, 1975.

Meetings Of Interest—International College of Surgeons will conduct course for nurses, medical assistants, and paramedical personnel at Sheraton Waikiki December 7, 8, and 9. Advance registration required—no fee for paramedics—contact Wm Houser, Int. College of Surgeons, 1516 North Lake Shore Drive, Chicago, Ill. 60610.

Consumer Credit Seminar—Sponsored by Retail Merchants of Hawaii—Thursday, November 20, 10:00 AM to 4:00 PM, Ala Moana Hotel. Will cover Equal Credit Opportunity Act, Fair Credit Billing Act, and 1974 amendments to the Truth in Lending Act. Has a direct bearing on medical economics—140 page booklet will give details. Registration fee includes lunch and materials—\$25.00. Contact Retail Merchants of Hawaii, Chamber of Commerce, Suite 215, Dillingham Transportation Building, Honolulu 96813.



To join or not to join, that is the question

At the September meeting of the Honolulu County Medical Society there was a bare quorum present when an important vote was taken.

The vote went 40 to 7. Forty people decided for a membership of around 800. What was it all about?

Prior to the vote, David Weihaupt, young staff man and director of the membership division of the AMA, told the audience that there were 360,000 physicians in the U.S.A.; that AMA membership overall numbered 212,000; that this membership was growing in numbers; that 173,000 of these were dues-paying members and that 85% of all eligible physicians were members of AMA. This portrays "organized medicine" as a pretty healthy and powerful entity.

Are you a part of it? That is the question.

One can look at it from either of two perspectives: From the grassroots up, or from the AMA down.

The Hawaii Medical Association holds its annual meeting October 25 and 26. The House of Delegates will include blocks of members from each of the four county medical societies. On the agenda will be a resolution to sever the mandatory tie-in between County, State and the AMA. This does *not* mean a severance of relationship with the AMA; all the resolution speaks to is to make membership in the AMA voluntary.

Only six states, Hawaii included, still mandate a tri-membership. You cannot become a member of one without having to join and pay dues to the other two.

If you feel rather strongly that your one and only allegiance is to your local county medical society (and to your State Association as well), then urge a vote FOR the resolution. You should then become completely consistent and logical in your thinking and urge another resolution that would allow voluntary membership of any one of the three entities!

Sure, and we could then build up local interest and power, you say! Oh yeah? Take another look at the first paragraph above. A measly 6% of the membership of HCMS, the largest and most powerful block in this state's medical community, participated. A minute minority "conveyed the sense of the entire block" that this resolution should be turned down, in essence.

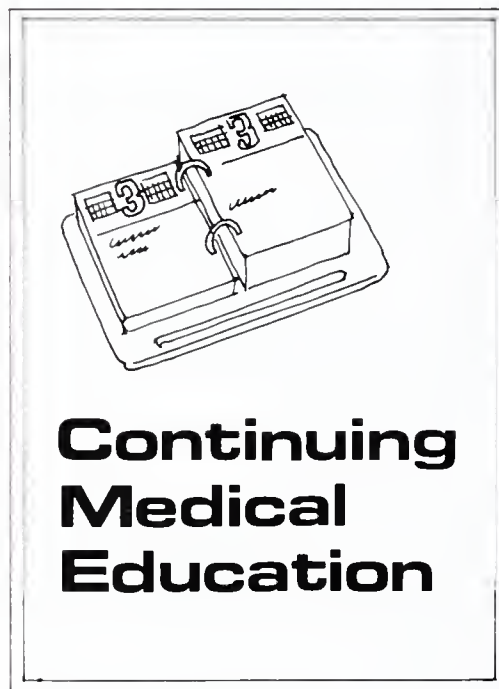
What kind of clout would we, at the county level, have in Washington, D.C.? Would DHEW pay the slightest bit of attention to 6% of a membership of 800? And what could the medical association of a small state like Hawaii do at the nation's capitol in dealing with restrictive rules and regulations imposed upon its members by DHEW? Even the specialty societies, of which the largest is the American Association of Family Physicians, cannot accomplish in Washington what the AMA can, and has, and will yet affect for all of us.

Now look at it from the other perspective. As in your specialty societies, you join the whole, but participate through local components on down the line. The cry is for the AMA to be re-

structured. Very well. Let's start inside the AMA by throwing out the 2,700-odd county societies, and the 50 state associations. Join the AMA primarily. With a membership of 212,000 physicians, most of them individual and direct members, card-holding, the AMA does indeed represent "organized medicine". Then, assign members according to state lines, grouping them for effective participation in medical politics; break up these groupings even further according to county lines, to increase this participation. Then, what's to prevent even further decentralization—into components centered at hospitals, for example? Your dues might go primarily to the AMA, which would then refund portions to the states, which would in turn rebate to a lesser component, and thus on down to the "grass-roots."

If one were to entertain the latter perspective, one would not have within them the uncomfortable sense of something being mandatory. Join—or don't join the AMA. Thereafter, you will become, if you join, a member of the whole, but will naturally want to work within one of its components, one closer to your own office.

J.I.F.R., M.D.



What's New In CME?

It is with regret we announce the resignation of Dr. Elisabeth Anderson as Director of HMA's Office of CME. She is going to California shortly. We thank her for her splendid efforts on behalf of CME in the islands and wish her great happiness.

We are pleased to announce that Kaiser Foundation Hospital and the Hawaii Heart Association were accredited by the CME Committee on September 25, 1975. Welcome to the growing list of accredited institutions in our State which now total seven: **Kauaikeolani Children's Hospital, Kapiolani Maternity Hospital, Kuakini Hospital, Wilcox Hospital, Kaiser Hospital, Hawaii Thoracic Society and the Hawaii Heart Association.** These seven institutions as well as the HMA are all offering *accredited* CME programs for Category I credits of the *AMA Physician's Recognition Award*. Accredi-

tation surveys are pending for Wahiawa Hospital and the American Cancer Society-Hawaii Division. We hope that most of the hospitals, voluntary health agencies and specialty societies will have applied for accreditation by the end of 1975.

Dr. John R. Watson took up his duties as director of CME at the John A. Burns School of Medicine on September 1st. He has been appointed a member of the HMA Medical Education Committee. He says his main role is to provide coordination and act as a bridge between the University School of Medicine, HMA, Hospital CME and voluntary health agencies, so as to avoid overlap and be sure that the wishes of practicing physicians are heard and that his needs are met. Bearing in mind the heavy demands of patients, and the ever increasing burden of paperwork on physician's time, CME must be organized to the physician's convenience and presented in a format that can be used when and where it is best for the doctor!

The CME Supplement to JAMA listed several courses to be presented at Kuakini Hospital. These courses have been postponed and will be listed in this column as soon as they are rescheduled.

Opportunities For Category 1 Credits

Listed below in the Calendar of Accredited Events are many opportunities for Category 1 credits. The Advance Registration form for the AMA Clinical Convention appeared in the September issue of the *Hawaii Medical Journal* and will also appear in the *AM News*. The HMA, Cancer Center, and School of Medicine will co-sponsor a 20-hour credit course on *Comprehensive Review of Clinical Oncology* to be held from October 15 to December 17 in the Mabel Smyth Auditorium. This series of 10 lectures will be held on Wednesday evenings from 7 to 9 p.m. and is open to house staff and practicing physicians.

**CALENDAR OF ACCREDITED
EVENTS—CATEGORY 1**

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS:

- Ongoing*
Kauikeolani Children's Hospital
- 1. Weekly Grand Rounds
 - 2. Weekly Monday Noon Seminars
 - 3. Visiting Professor Program
- Kapiolani Maternity Hospital
- 1. Tuesdays—CME Program, 1:00-2:00 p.m.
 - 2. Grand Rounds, Wednesdays, 7:30-8:30 a.m.
 - 3. Visiting Professor Programs (see Special Events)
- Kuakini Hospital
- 1. Hematology Rounds, Monday, 1:00-2:00 p.m.
 - 2. Gastroenterology, Tuesday, 8:00-9:00 a.m.
 - 3. Oncology Conference, Thursday, 8:00-9:00 a.m.
 - 4. Endocrine Conference, 2nd Wednesday each month, 1:00-2:00 p.m.
 - 5. Medical Statistics, 3rd Tuesday each month, 1:00-2:00 p.m.
- Wilcox Hospital (Lihue)
- 1. Department of General Practice Meeting—last Wednesday
 - 2. General Medical Staff Meeting—2nd Tuesday
 - 3. Clinical Review Meeting—Alternate Mondays at noon
 - 4. Tumor Conference—First Thursday

SPECIAL EVENTS

- October 20-24 Pathology Review, USC at Mauna Kea Beach Hotel.

- November 17-20 Sixth Hawaii Emergency Physician Seminar sponsored by HMA EMS Program and Hawaii Chapter of American College of Emergency Physicians; at Kaiser Hospital Pacific Bldg. Auditorium; registration: \$10; 12 hours credit. For more info contact: EMS Office, 538-9011 x 471.
- November 29-December 5 American Medical Association, 29th Clinical Convention, Sheraton Waikiki, Honolulu.
Contact: Frank A. Gray, AMA Convention, Services Department, 535 N. Dearborn St., Chicago, Illinois 60610.
- December 5-9 International College of Surgeons, U.S., Section Annual Meeting, Sheraton Waikiki, Honolulu. (A preliminary program is in the HMA office.)
Contact: Marilyn Lento, PRC, International College of Surgeons, 1516 Lake Shore Drive, Chicago, Illinois 60610 or HMA (CME Office)
- December 5-11 Cleveland Academy of Medicine, Kona Surf/Sheraton Maui.
Contact: Donald Mortimer, 10525 Carnegie Avenue, Cleveland, Ohio 44106.

1976

- January 17-24 Prenatal Medicine; USC at Royal Lahaina, Maui
- January 18 Medical Emergencies in the Elderly, presented by the American Geriatrics Association and the HMA, to be held at Straub Clinic, 8:30-4:30. Speaker: Thomas Criley, M.D.
Contact: L. Clagett Beck, M.D., 523-2311.
- February 15-19 Sports Medicine for Primary Physician; Lihue, Kauai; Hawaii Medical Association EMS Program.
- October 3-8 "Sixth Asian-Pacific Congress of Cardiology" sponsored by Hawaii Heart Association, at Sheraton Waikiki Hotel. For more information contact Morton Berk, M.D.

1978

- April 1-7 Pan Pacific Surgical Conference, Hilton Hawaiian Village.
Contact: Cesar B. deJesus, M.D., Pan Pacific Surgical Association, 236 Alexander Young Building, Honolulu, Hawaii 96813.

OUT OF STATE:

- American College of Physicians; regional meetings and programs as scheduled below:
- October 16-18 "The Clinical Spectrum of Adult Heart Disease" at Albuquerque, New Mexico.
- October 17-18 Fargo, North Dakota (Kahler Hotel)
- October 20-23 "Postgraduate Course in Endocrinology and Metabolism" at Durham, North Carolina.
- October 20-24 "Contemporary Internal Medicine" at New York, N.Y.
- October 27-31 "Internal Medicine: Review & Advances" at Sacramento, California
- November 2-3 "Liver Disease for the Internist—State of the Art 1975" at Chicago, Illinois
- December 4-5 Winston-Salem, North Carolina
- December 4-6 San Antonio, Texas
- December 8-12 "Fluid & Electrolyte Balance, Hypertension and Renal Disease" at Chicago, Illinois

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For further information: American College of Physicians,
4200 Pine Street, Philadelphia, Pa. 19104.

NYU Post-Graduate Medical School: programs as scheduled below:

October	"Advanced Dermatologic Surgery";
25-26	12 hours credit
November	"Current Status of X-ray Therapy in Dermatology"; 12 hours credit
13-14	

For further information:

Office of the Associate Dean
NYU Post-Graduate Medical School
550 First Avenue
New York, N.Y. 10016

October	Annual Assembly of the American College of Chest Physicians, Anaheim, California.
26-30	Contact: Alfred Softer, M.D., Executive Director, Am. Col. of Chest Physicians, 911 Busse Highway, Park Ridge, Illinois 60068

November	60th Annual International Scientific Assembly of Interstate Postgraduate Medical Association; at New Orleans Marriott Hotel; 20 hours credit; fee: \$40 advance or \$60 at meeting.
3-6	

For more information:

Dr. Alton Ochsner, Program Chairman
Interstate Postgraduate Medical Assn.
P.O. Box 1109
Madison, Wisconsin 53701

November	"Neoplasms of the Skin and Malignant Melanoma" at Shamrock Hilton Hotel, Houston, Texas; 12 hours credit.
13-14	

Contact: University of Texas System Cancer Center, M.D. Anderson Hospital & Tumor Institute, Texas Medical Center, Houston, Texas 77025.

December	"Phenomenology & Treatment of Depression" at Shamrock Hilton Hotel, Houston, Texas; 15½ hours credit; fee: \$150.00.
4-5	

For more information, contact:

Office of Continuing Education
Baylor College of Medicine
Texas Medical Center
Houston, Texas 77025



Hawaii Academy of Family Physicians' Newsletter

J. I. FREDERICK REPPUN, M.D.

NEW MEMBERS—Glenn Stahl MD has joined the Windward Medical Clinic and is a new Associate member. John W. Newman MD has joined the Hilo Medical Group; he is

a Fellow and Active. **James Y.S. Tom** is a new Student member, UHSM II '78. We welcome you all.

DROPPED—from our membership are: **Guy Heder MD** of Kahuku; students **George Sarant** and **Joanne A. Rosario**.

NEWS of MEMBERS—**Felix Lafferty** has decided not to run for the A.A.F.P. Board of Directors this year. His name, however, has been submitted for renomination to the national Committee on Mental Health. **Mark Wentworth** has become a Fellow as an Inactive member; he is moving to Ewa. **Bill Kirker** is no longer with the Waianae Coast Comprehensive Health Center; he is no longer a member of HAFP. A recent ad in the newspapers stated that **Dave Hobbs MD** in Family Practice and **Terry Claggett MD** in Internal Medicine have joined **Vernon Boido** and **Fred Dodge** at WCCHC. **William Ahuna MD '75** (UHSM) is now at Seattle's Group Health Hospital.

SPECIAL ITEM—we were saddened to hear of the recent demise of **Marie Faus MD**, a former member of HAFP. Our condolences go to Bob Faus MD who was also a member formerly.

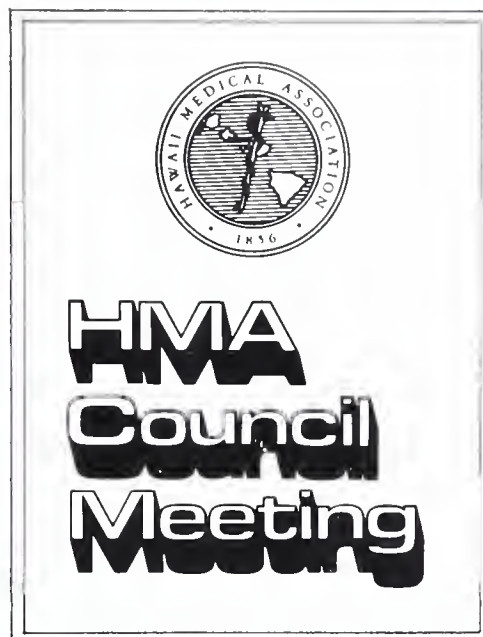
COURSES FOR CREDIT—The Sports Medicine Seminar scheduled for February 1976 on Kauai will be held at the Kuilima on Oahu's North Shore instead. AAFP Category P credit is being sought for the American Joggers Ass'n meeting 11-13 December (but will probably be turned down!). Wahiawa General Hospital's "Endoscopy in the Diagnosis of GI Diseases" by Dawson Durden MD 29 July is Cat P for 1 hour. Dr. Saul Krugman's "Diff. Dx of the Child with a Rash" on 30, 31 July qualified for ½ hour P. "Office Work-up and Management of the Hypertensive Patient" by Frank Finnerty MD, visiting professor, on 14 August was 1 P—all of these at Wahiawa. Some active eager-beavers up on the plateau! Kauaikeolani Childrens Hospital Monday noon conferences 18 Aug to 29 Sept under UHSM Peds Dept and KCH were category P for a total of 6 hours.

DON DICKERSON MD—has written HAFP a letter stating he is willing to come to Hawaii each July/August/September to do locum tenens. The past two summers he has done so in Kohala for **Drs Eveleth** and **Padwick**. The poor guy lives in Palm Desert, California, where "the desert is unkind" during those months. Contact your Executive Secretary, if any of you are interested.

MEAD JOHNSON LABORATORIES—is offering awards up to \$1,200 annually to deserving F.P. Residents beginning in 1976. In July of that year, Hawaii hopes to have a Family Practice Residency going outside of the one already in effect at Tripler. Those interested, please apply through our Executive Secretary.

HAWAII MEDICAL ASS'N—meets in its House of Delegates 25, 26 October. Got any burning issues on your conscience? Submit your resolutions through your delegates or councillors right away!

Next Dinner Meeting is November



Thursday, August 7, 1975, 5:30 P.M.
Mabel Smyth Lanai

CALL TO ORDER

The meeting was called to order by President Winfred Y. Lee. Also present were Drs. William Dang, R. Varian Sloan, Grover Batten, George Mills, Herbert Chinn, George Goto, J.I.F. Reppun, Arnold Siensen, John Edwards, Carl Lum, Ann Catts, Rowlin Lichter, John Kim, Sakae Uehara, Verne Adams, and Marion Hanlon plus Drs. Douglas Bell II and Calvin Sia.

MINUTES

The minutes of the July 11, 1975 meeting were approved as circulated.

TREASURER

The financial statement for June 1975 was reviewed. The treasurer noted that the Common Fund Executive Committee would meet soon to review the pension plan. A motion to review only the monthly Income and Expense page of the

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financial report and that detailed reports be made to the Council on a quarterly basis failed to pass.

ACTION:

It was voted to accept the financial report for June 1975 subject to audit.

UNFINISHED BUSINESS

(Council meeting of July 11, 1975)

A. Legislation: Dr. Goto noted that in view of the developing legislation being recommended by various HMA committees, the Council might wish to consider employing a legislative counsel for the remainder of 1975 and early 1976.

ACTION:

It was voted to request the Legislative Committee to submit their recommendation regarding a legislative counsel including the budget requirement at the next Council meeting.

B. EMS: Dr. Dang reviewed the recently signed EMS contracts with the Department of Health and with the City and County of Honolulu. He proposed that all fiscal matters regarding the EMS project be handled by the HMA Finance Committee noting that the EMS Board often is not aware of various fiscal matters as they relate to HMA Policies. The organizational chart of the EMS project was reviewed.

ACTION:

It was voted to appoint the fiscal officer, Mr. Tom Thorson, or his delegate as an ex-officio non-voting member of the EMS Board. It was further voted to refer the guidelines on HMA policies to the project director.

C. PL 93-64I: Dr. Dang reported that a committee is meeting to discuss the functions of a health service agency if it is determined that there will be a health service area for the State. The Governor's Ad Hoc Committee on PL 93-64I will meet on August 12. It has not yet been determined whether there will be no agency or a single agency for the State.

D. Cancer Commission: The Hawaii Tumor Registry is working on the submission of a new contract to the Cancer Center. The Commission is also considering the implementation of **Cancerline** which places mobile terminals in hospitals for rapid retrieval of information relating to cancer care.

E. PSRO: The progress report for July was circulated. Dr. Lee noted that he will meet with representatives of HEW in San Francisco to discuss various aspects of the planning contract.

F. Resolution re Unified Membership: At the previous Council meeting, the Bylaws Committee was directed to prepare a resolution in proper form for submission to the House of Delegates on the matter of unified membership.

ACTION:

It was moved and seconded to oppose the Resolution. It was moved and seconded to postpone action until the next Council meeting to give the Council an opportunity to become fully informed on the question of unified membership. It was moved, seconded and passed to table the motions.

G. Renovation Report: The blueprints and projected expense for renovation of existing administration offices were presented in detail. The costs of renovation were not fully determined and the architect suggested he would need further detail prior to a firm commitment. There was considerable discussion on the proposal including questions regarding authority to approve such proposals, whether it might be possible to considerably expand the Mabel Smyth Building by the addition of an entire new floor, and whether or not the HMA HCMS plans to further explore ownership of their own quarters.

ACTION:

It was voted to approve the concept of the changes proposed by the architect and that Council obtain more substantial figures to be presented to the House of Delegates.

It was moved and seconded to authorize up to an additional \$1500 to provide the figures needed for presentation to the House of Delegates. The motion was defeated by a single vote. It was voted to obtain further estimates from contractors. A motion to appoint a special committee to carry out this function failed to pass.

It was voted to appoint a special committee to look into all possibilities and come up with a concrete need and statistics by which the Council can arrive at some conclusion. The President announced he would appoint the Site Committee plus some additional members to carry out this task.

H. Ad Hoc Committee on Medical Malpractice: The committee presented eleven policy statements on the subject of medical malpractice. The consensus of Council action will be distributed to all HMA members along with a glossary of terms.

I. Mutual Insurance Company: At the last Council meeting, it was agreed to participate with the Hospital Association of Hawaii in forming a corporation to explore the feasibility of developing a mutual insurance company. The first meeting of the Board of Directors will be held August 12. Representing the HMA on the Board are: Drs. Chun-Hoon, Lum, Dang, Lee, Lum, West, and Mr. Thorson.

Mr. Thorson announced that Northern California has just begun their reciprocal and has invited HMA to join with them now or in the future.

OLD BUSINESS

A. Hawaii Health Services Research Center: The HMA Executive Committee reviewed the proposal of the Hawaii Health Services Research Center in detail. They recommended that the project not be endorsed and therefore that there not be any representative from HMA designated to serve on the Board of Directors.

ACTION:

It was voted to accept the recommendation.

B. HPRO: Dr. Lee discussed his ideas regarding the establishment of a HMA subsidiary organization to be referred to as the Hawaii Professional Review Organization (HPRO). This organization would conduct peer review to include claims review and professional standards review, on both an inpatient and outpatient basis, as part of our commitment to continue the quality of medical care in Hawaii.

ACTION:

It was voted to form a committee to look into this concept further.

NEW BUSINESS

A. Medicare brochure: The Oklahoma State Medical Association has prepared a leaflet on the subject of Medicare for distribution to all Medicare patients. It was agreed that HMA should also print a brochure and make it available to all members.

ACTION:

An ad hoc committee was appointed to prepare a leaflet on Medicare. Members are: Drs. Reppun, Edwards and Lichter.

B. Resolution of Authority: A resolution of authority for signature on contracts, bids, or proposals was reviewed.

ACTION:

It was voted to accept the resolution.

ADJOURNMENT

The meeting adjourned at 11:10 p.m.

R. Varian Sloan, M.D.

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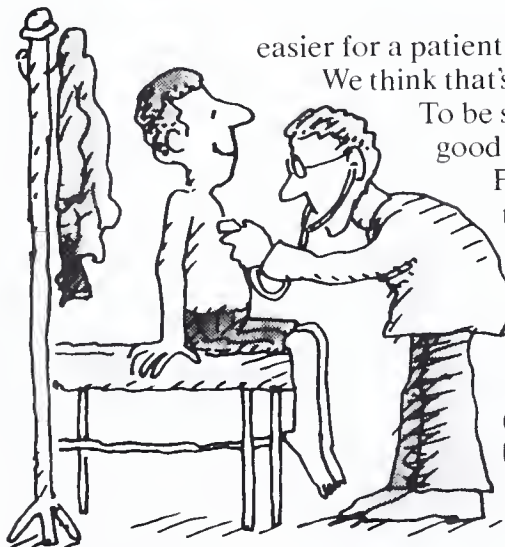
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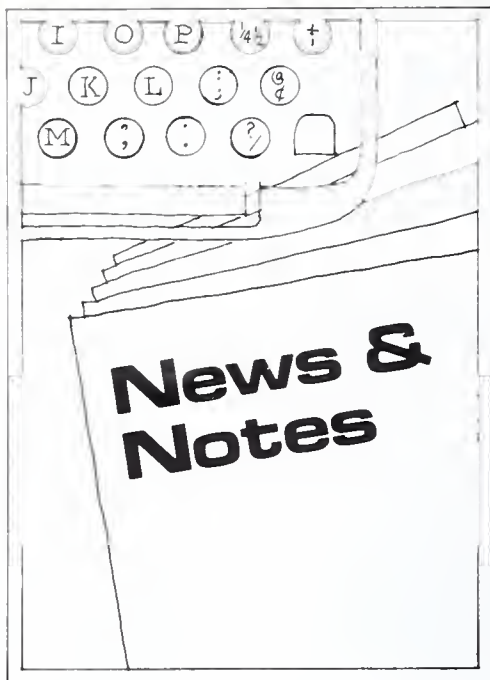
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HENRY N. YOKOYAMA, M.D.

Life In These Parts

David Pang, our roving reporter overheard the following conversation on Kinau II between **Jim Marnie** and a cute young floor nurse: Jim: "Where you been? Haven't seen you in a long time." Sweet young thing: "I was taking a course." "Intercourse?" "No, I wish... but an oncology course..."

Kuakini pathologist **Grant Stemmerman** looked up from his microscope and with serious mien said, "We have something which should be written up. It has all the ramifications of a great Japanese novel..." Stemmy told the story of a 46-year-old man who had been shunned all his life by both family and society because of his foul mouth odor. Miserable and friendless, he started to drink and fortunately developed GI symptoms... He saw **T. Fukumura** who on colonoscopy discovered a gastrocolic fistula which was repaired forthwith... Stemmy was ecstatic: "Just imagine, shunned even by his own mother... It would make a marvelous plot for a great Mishima novel... Life really starts for this poor fellow at age 46." Later, at a surgical conference, the resident related how the poor fellow would be accused of farting by his school mates whenever he burped in school.

At a Straub Friday noon conference, **Rod Matsubara** had quoted something from "Englishman" Dr. Forbes, where-upon Englishman **Phil Jones** corrected, "Dr. Forbes is a Scot... It's like saying Dr. Matsubara, Chinese physician." Stan Shimoda piped up from the back of the room, "What's the difference... All haoles look alike..." (As told by **Harry Arnold Jr.**)

One hectic Friday, **Nami Kominami** had her dander up because the critical temperature recordings in the patient's chart were missing and in a most unobtrusive way was damning the whole world while the nurses cowered in a far corner. Along came pathologist **Jim Navin** who observed, "Nami, TGIFA eh?" (Thank God It's Friday Again!) Replied Nami, "I rather like POETS." (Piss On Everybody—Tomorrow's Saturday.)

Teenage alcohol abuse has reached epidemic proportions on the mainland. In Hawaii, teenage drinking is thought to be on the rise, but appears to be a "hidden problem." Straub pediatrician **Bob Latta** and Northwestern University student Phillip Lee surveyed 44 agencies and institutions to determine the exact extent of juvenile drinking in Hawaii. Bob reports that "very little substantial detailed information is available to confirm or deny what is suspected." Bob is concerned with teenagers under the age of 18 since the sooner an individual begins the use of alcohol, the more likely he is to experience problems from alcohol usage later in life.

The Honolulu Medical Group is offering CPR courses to the general public for \$10 per course. The classes will be two 2-hour sessions...

HMSA statistics reveal that only 19 nonclinic and six clinic physicians earned more than \$30,000 from Medicaid in 1974. Of the 1,350 practicing physicians in the Islands, 1,167 are participating in Medicaid. Of 609 nonclinic physicians, 138 (22.6%) received less than \$600, and 12 of the 558 clinic physicians, earned less than \$600. Also less than half of the nonclinic physicians earned less than \$2,500. The 19 non-clinic physicians who averaged more than \$30,000 from Medicaid include nine GPs, four OB men, two internists, one radiologist, one dermatologist, one orthopod and one psychiatrist.

A Mike Wood of Curtis Street suggested to Governor Ariyoshi that when they get around to tearing down the old stadium, they should auction the seats for souvenir hunters. When the Yankee Stadium was being remodeled, Straub Physician **David Eith** brought a box seat for \$20. His wife recalls, "He lugged that thing from the stadium to our hotel on the subway... Then he carried it on the plane all the way to Honolulu... We have three box seats at Honolulu Stadium and he wants to buy those too."

In September, **Jim Penof** had a close call in London. When Jim tried to get a room at the London Hilton where the cabbie dropped him, the desk clerk said, "We're full now, but if you'd care to wait an hour or so I might have a room available." So rather than wait, he tried the Intercontinental next door where he got a room. Then Jim dropped off his bags and walked back past the Hilton to a small restaurant for lunch. Only minutes later, he heard the bomb that exploded in the Hilton lobby killing two and injuring 41. Jim collects, "I must have walked right past the bomb. If I had waited for a room at the Hilton, I might have been sitting there when it exploded."

From Tom Horton's column: "Normally when you see people rubbing a staple in the ear these days it means they're trying to lose weight or quit smoking by acupuncture methods. But when a resident of the Ala Wai boat harbor noticed that a lithe beauty in a bikini had her ear stapled, there was this revealing exchange... 'Sheri, you trying to lose weight?' 'Nope.' 'Quit smoking?' 'Nope.' 'Then why the staple?' She put her hands to her chest and said, 'The doctor said they'll grow two inches in four weeks.' This much is confirmed by DR Albert Michely, who operates something called the Ear-Staple Clinic: He and others have been experimenting with the ear-staple method to help women increase their measurements and he says the results so far have been encouraging. We did not get into figures. (Four days later, we noticed that Albert Michely was named in a temporary restraining order filed by the State Office of Consumer Protection against "practicing medicine without a license" and to stop calling himself a "doctor." The State also reported that Michely has claimed that he could treat such diseases as asthma, cancer of the bone marrow, duodenal and gastric ulcers, angina pectoris and heart attack. Also, the State warned "Albert Michely's alleged program for breast enlargement can only be considered experimental in nature and any person purchasing such treatments should exercise caution.")

Shoji Shibata (M.D. with a pharmacology doctorate) and chemist **Ted Norton**, both with the UH Department of Pharmacology report that a substance called AP-A obtained from a sea anemone species known as *Anthopleura xanthogramica* improves the heartbeat in animals without increasing the rate and causing arrhythmias. Their research was supported by the Heart and Lung Institute of NIH and the Hawaii Heart Association.

Professional Moves

True to form, the Year of the Hare has been treading softly till now, but there has been a sudden surge of new physicians in September... Internist **Birendra Huja** joined

(continued page 376)

"Kid, this stuff is the bananas."



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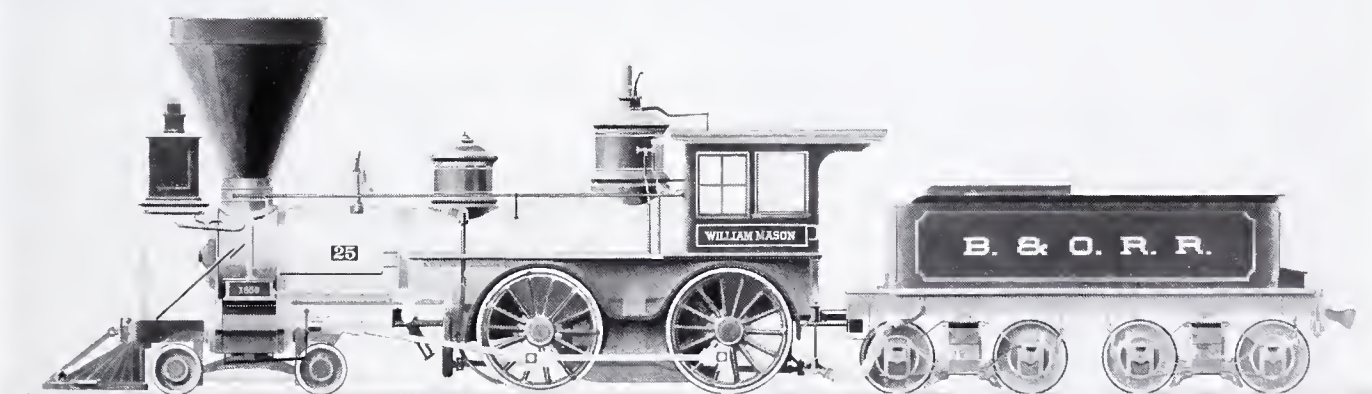
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The William Mason (1856)

When diarrhea has him reeling...



Diarrhea can hook anyone. When it does, physicians and patients both want prompt control of diarrheal symptoms. Lomotil will usually control diarrhea promptly.

This rapid action can halt the emergency aspect of diarrhea and is comforting and reassuring to the patient. Electrolyte and

fluid losses can be corrected while the specific cause of the diarrhea is being determined. If an infective agent is the cause, appropriate specific therapy should be given along with Lomotil.

Lomotil is contraindicated in children less than 2 years old.

Lomotil[®]

TABLETS LIQUID

holds the line.

Each tablet and each 5 ml. of liquid contain diphenoxylate hydrochloride 2.5 mg (Warning: May be habit forming), atropine sulfate 0.025 mg

Our "Angels"

IMPORTANT INFORMATION: This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or Narcan® (naloxone HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with special caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis. In severe dehydration or electrolyte imbalance, withhold Lomotil until corrective therapy has been initiated.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage. Use with care in patients with acute ulcerative colitis and discontinue use if abdominal distention or other symptoms develop.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing, hyperthermia, tachycardia and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria, paralytic ileus, and toxic megacolon.

Dosage and administration: Lomotil is contraindicated in children less than 2 years old. Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonsfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist may be used in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of 1/2 ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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Coping With Life

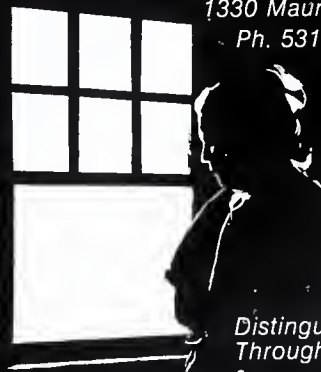
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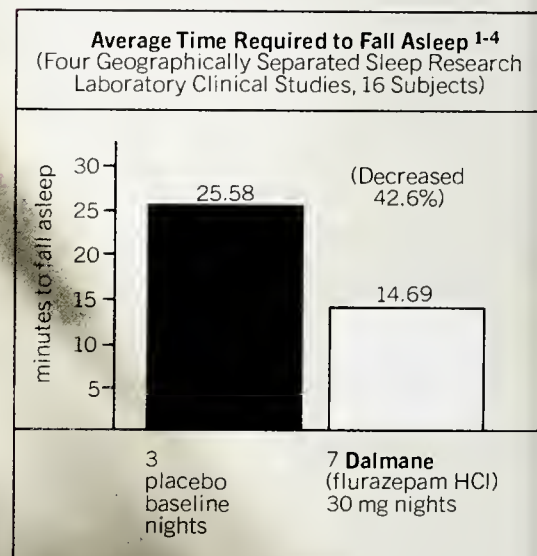
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As demonstrated below, Dalmane induces sleep within 17 minutes, on average.¹⁻⁴



And for those with trouble staying asleep or sleeping long enough...

...sleep research laboratory clinical studies prove: Dalmane decreases number of nighttime awakenings and increases total sleep time.⁵

Dalmane (flurazepam HCl) is relatively safe, seldom causes morning "hang-over"

Dalmane is generally well tolerated. The usual adult dose of 30 mg should initially be lowered to 15 mg for the elderly and debilitated, to help preclude oversedation, dizziness or ataxia. Appraisal of possible risks is suggested before prescribing.

REFERENCES:

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3. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
4. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
5. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly

or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

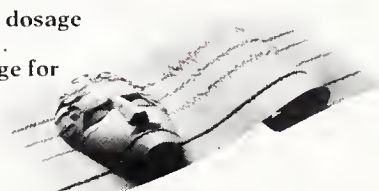
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the Leeward Clinic, anesthesiologist **Louis Wu** joined the Medical Anesthesia group, pediatrician-urologist **William Yarbrough** joined the Straub Clinic, and internist **Edmund Whang** joined **Timothy Wee** in Wahiawa. The Kaiser Group added anesthesiologist **Alfred Anderson**, and family physicians **James Campbell III** and **James Windeck**, but lost ophthalmologist **John Corboy** who opened offices at 305 Royal Hawaiian Ave and at 916 A Kilani Ave, Wahiawa. The Waianae Coast Comprehensive Health Center announced that GP **Dave Hobbs** and internist **Terry Claggett** have joined **Vernon Boido** and **Fred Dodge**. Cardiovascular and thoracic surgeon **George Chung** opened at 1448 Liliha Street. On the Big Island, surgeon **Minolu Chang** joined **Thomas Mar** in Kailua-Kona, internist **Thomas Chen** opened at 140 Kinooale Street, Hilo, and GPs **John Newman** and **John Taylor** joined the Hilo Medical Group. . . . On the Garden Island, internist **Larry McKnight** joined the Kauai Medical Group and on Maui, orthoped **C. E. Probst** opened in Kahului . . .

Miscellany

An English matron who had decided to move to Connecticut found an old New England house to her liking. When she returned to England to get ready to move, she couldn't recall where the bathroom was in the house. So she wrote asking where the W.C. was. The Connecticut Yankee shrewdly guessed that W.C. stood for the Wesleyan Church and replied thusly: "The W.C. is about 8 miles away. As a matter of fact, my wife and I were married there. It is located in a lovely grove of trees out in the country and is a favorite picnic spot. It seats 350 people but is so popular that people frequently have to stand. And they love to make it an all-day affair. My wife is very distressed since she can only go once every 6 months because of the distance. . . ." (A **Betty Anderson** contribution)

Elected, Honored and Appointed

The following physicians were awarded certificates of recognition at Kuakini Hospital's 75th Anniversary Banquet in September: **Tadao Hata**, **Kyuro Okazaki**, **Toru Nishigaya**, **Masato Mitsuda**, **Minoru Kimura**, **Isaac Kawasaki**, **Takeo Fujii**, **Thomas Fujiwara**, **Noboru Oishi**, **Roy Tanouye** and **Henry Oyama**.

Ralph Cloward, who was recently elected president of the Western Neurosurgical Society for 1975, has the dubious unprecedented distinction of holding three offices in four days. He was VP for 1974 but shortly before the 1974 Annual meeting, the president-elect died and Ralph was elected President-elect. Four days later, he was elected President. Ralph is arrangements chairman for the 1975 annual meeting of the Society at Mauna Kea Beach Hotel . . .

Locker Room Jokes

As we showered after a vigorous tennis game, **Ben Tom** asked, "What happens when you goose a ghost?" "Give up." "You get a handful of sheets."

George Suzuki in his birthday suit related the following dialogue: Tom announced, "I just got my girlfriend a condominium. . . ." Not-so-bright **Dick** suggested, "You should have gotten her a diagram. . . ."

Two Portuguese men went hunting and came across a pretty maiden cavorting nude in the woods. . . . Said one hunter, "Are you game?" "Yes!" she replied enthusiastically. The other hunter raised his gun and shot her tot! (A **Dick Dennis** special)

Sportsmen

Of Bees and Golfers . . .

On a fateful Memorial Day, **Cool Wakai** was shooting his average game at the Wailea Golf Course on Maui. Then a yellow jacket found his right thumb to its liking on the 12th

Hole. . . . Cool, posthaste, applied a tourniquet and coolly inflicted a bleeding laceration with a rusty knife we proffered. He sucked out the venom in the best tradition of snake bite treatment and popped an antihistamine tab from his golf bag. . . . We watched with fascination and sympathy. . . . Then to our surprise, with thumb still tourniquetted and swollen, he proceeded to par in much to our chagrin, thus winning the jackpot with a gross 79. . . .

Tom Kobara recalled the time he was helping **Hide Oshiro** search for a lost ball in the Mid Pac 11th hole rough. When Tom reached into the bush for the lost ball, he grabbed a yellow jacket nest instead and received 8 simultaneous stings. Several holes later, he hit a golf ball squarely into Hide's buttocks as Hide walked ahead. . . . Accidentally, of course. . . .

During a Hawaiian Resorts Invitational Tournament on Kauai several years back, our drive landed on the left side of the 13th Hole at Wailua Golf Course, next to a small fruit tree. Just as we hit our 3 wood, we felt a sharp sting on our right forehead. When we looked up, there less than a foot in front of our face was the largest bee nest covered with yellow jackets bristling their wings. . . . We yelped and ran down the length of the fairway swinging wildly with our club to fend off the swarm of angry bees buzzing around our heads. . . .

"We all know a doctor or two who are not adverse to throwing a little bull around. . . . But there are few doctors who'll take the chance of having a bull throw them around. . . ." **Jeffrey Goodman**, Kapaa physician entered the bull riding event in the recent Wailua Saddle Club rodeo and was tossed off under 3 seconds. Jeff sez, "I wasn't scared until I hit the ground and felt a little shaky in the knees." "And that's no bull."

Three Maui physicians were among the 387 participants in "Run for life" race, a benefit for the Makana Foundation. The trio entered the 40-49 age group and finished the 8.4 mile course, **Russell Stodd** in an hour and 4 min, **John Withers** in an hour and 14 minutes and **William James** 15 minutes later.

We have to check into **Ross Hagino's** tidbit about a resolution before the HMA house of delegates that will require perennial golf winners, **Al Parez** and **William Dang** to use a handicap based on their regular club handicaps as well as handicaps computed from their golf tournament winning scores. (Sounds sensible)

4th Annual Kuakini Hospital Golf Tournament, First place: **Al Parez** 80-13-67; 2nd place: **Quint Uy** 81-12-69 (List of other winners pending) (The following feature is an Allan Young Special)

7th Annual St Francis Hospital Golf Tournament (Held at Mid Pac CC Tuesday, September 16). Co-chaired by **Richard Ho** and **Allan Young**. 40 gollers (with honest handicaps) played. At tee-off time, **Winfred Chang** (one of the star players) was called out on a medical emergency. Accuracy was the "name of the game" as more than 30 players hit a 40-foot circle on the 1st and 17th holes to win money prizes. Some ringers hit both zones, while a few duffers missed both. Pro **Dick Ho** was the only one to land within a 10-foot circle on the 4th hole, and semipro **Winnie Lee** was the lone winner on the 11th hole.

The awards banquet was held the same evening at the Cathay Room, Hawaiian Village Hotel. "**Gorilla**" **Alvin Paraz** had low net 65 and won the Sister Maureen Trophy and the perpetual Low Net Trophy. **Dick Ho** shot gross 74 to win the Low Gross Trophy. **Paul Tamura** got the Lemon Trophy by dumping 3 balls into the water on the 5th hole and shooting a high net of 90. **Francis Au** had high gross with an incredible 119. For this monumental feat, Francis received both the Banana Trophy and the Perpetual Finger Trophy. **Dick**, **Paul** and **Francis** will help **Al Paraz** put on another fun tournament next year. ■

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Both often



Predominant
psychoneurotic
anxiety

Associated
depressive
symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor

neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive dis-

orders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anti-convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or

two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al*: *Dis Nerv Syst* 30:675-679, Oct 1969.
2. Hollister LE, *et al*: *Arch Gen Psychiatry* 24:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics* 11:438-441, Sept-Oct 1970.

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of child-bearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle



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in psychoneurotic
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spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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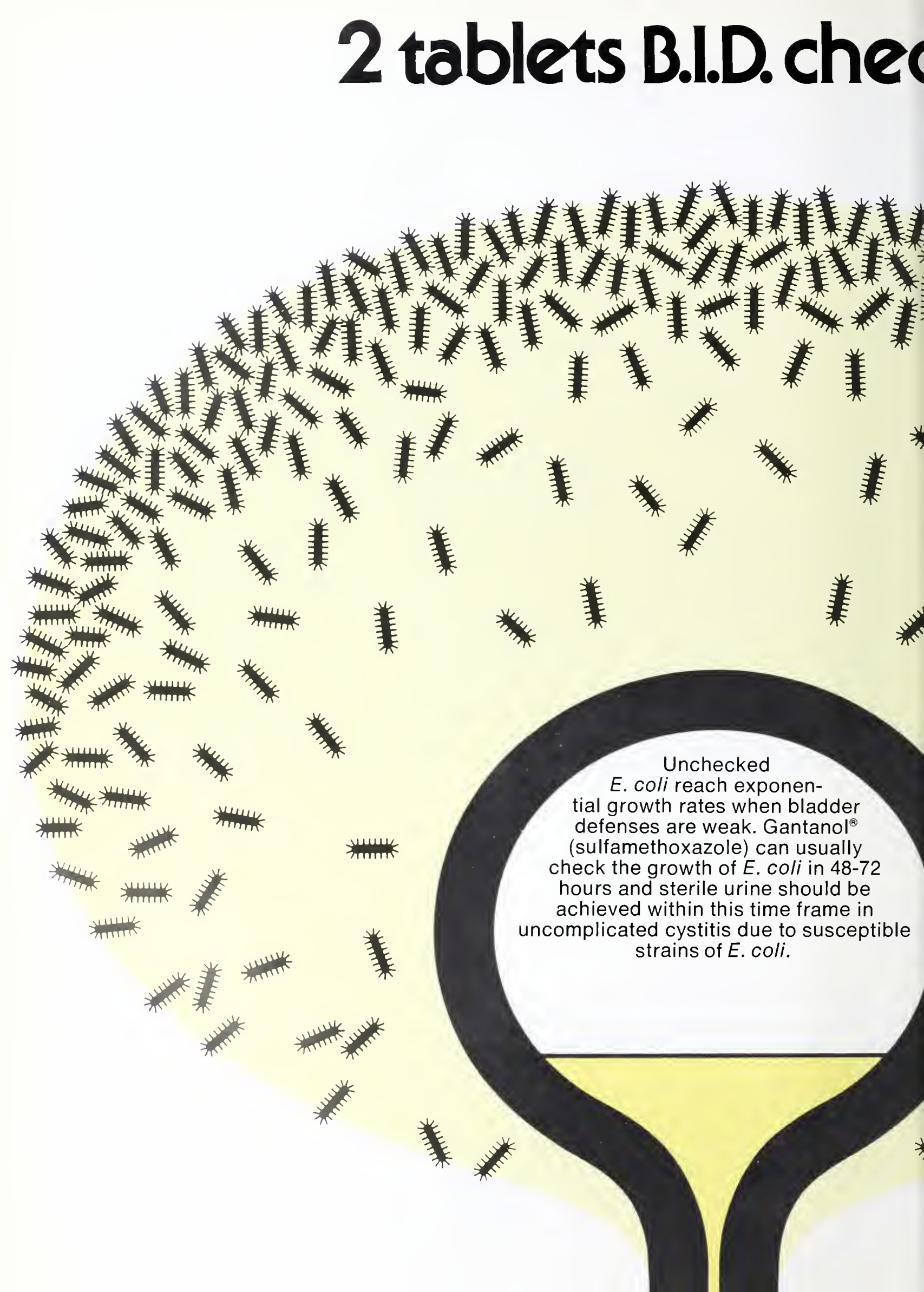
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Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprolthrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

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Should a specially prepared package insert be made available to patients?

Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration



Dr. James H. Sammons
Executive Vice President
of the American
Medical Association



The idea of a so-called patient package insert has been around for a long time. Many physicians already use written instruction sheets to provide patients with information about the drugs they are taking. And some physicians give verbal instructions; but in too many instances these are what I call eye-glazing exercises. I have seen patients sit with glazed eyes listening to a rapid-fire lecture by a hurried physician who has 20 people out in his waiting room. These patients aren't given sufficient understanding and therefore do not follow instructions. So I think the idea of an official package insert for patients is a good one. Perhaps we should really think of this kind of information simply as an extension of drug labeling.

The benefits of patient involvement

Many physicians may not realize how frequently a patient obtains his drug information from Aunt Tillie or the next door neighbor. And this information is almost always bad or irrelevant to the case at hand. Furthermore, the incentive to go along with a prescribed program is slim if the only reading matter the patient receives, along with his prescription, is a bill.

As an educator I am impressed by the principle that the best way to get someone to do something is to involve him in the process. So the

I think there are advantages as well as some real disadvantages in a patient package insert. When you begin to use semi-medical or medical terms to describe complications or possible sequelae of disease or treatment, you may frighten the patient—particularly since the more highly sophisticated patient is not the one who is going to read the insert. The patient who will read it is the one most susceptible to fright and confusion by the language.

On the positive side, a package insert will probably give the patient better insight into why he is being treated the way he is, and it may give the physician a little bit more time. But it does not remove from the physician the need or obligation to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should be warned of the possibility of serious side reactions—to know what the real dangers are. But it doesn't do a bit of good to indicate that a patient on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that fright engendered by the insert may possibly outweigh the potential good.

main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is

no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a pa-

tient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

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Changing Concepts of Responsibility

JOHN J. LOWREY, M.D., *Honolulu*

There seems to be no unanimity of opinion as to the causes or solution for our country's depressed economy. Such stirring phrases as "bite the bullet," and "ask not what your country can do for you, but what you can do for your country" seem to fall on deaf ears. Perhaps our previously rich government, like an overindulgent parent, has spoiled our citizens and, by its policies, eroded their independence and sense of responsibility. Maybe the loss of a sense of personal responsibility is part of our problem.

Responsibility

Rogert's Thesaurus dissects the meaning of responsibility into three categories: solvency, duty, and trustworthiness. Solvency refers to soundness, solidity, reliability, and unindebtedness. Duty refers to the moral obligation-incumbency, liability, accountability, amenability, and blame. Trustworthiness refers to reliability, dependability, unfalseness, incorruptibility, and inviolability.

What I hope to demonstrate to you in this essay is that first, the meaning of responsibility to persons today is very different from its meaning to their peers of a few generations back, and that social changes and legal interpretations of laws are creating what, for want of a better phrase, I term "a cult of non-personal responsibility." Second, to submit some changes in attitudes of responsibility in my own profession which I feel will have repercussions in the delivery of medical care.

This essay is not meant to be judgmental, only descriptive of the changes which I feel are having profound effects on all our citizens, young and old. Whether the changes are for better or worse is for each person to judge. I can't help but voice my own opinion at times. As long as the affluent society persisted, there was little concern; now many seem to be questioning our course.

A Cult of Non-Personal Responsibility

A cult of non-personal or non-individual re-

sponsibility to me is created when a person begins to feel he does not need to take responsibility for himself because someone else, his group or the state will. Dr. Thomas Szasz, professor of psychiatry at Syracuse, speaking on the television show, "The Advocates," stated, "A man who is not given responsibility becomes less of a man." Advocates of women's lib would insist this be altered to say, "A person who is not given responsibility becomes less of a person." Well-meaning laws to help those in distress seem to be applied for other purposes than to help those for whom they were written, and are used to shirk what previously was considered a matter of personal responsibility.

A simple example of this is as follows: The 1974 Legislature revised Section 392-21 of Hawaii's Temporary Disability Insurance Laws to make lost time from work due to normal pregnancy eligible for benefits under Temporary Disability Insurance. Prior to this act, many girls were working until close to their confinement date and returning soon afterwards. Within a few weeks of the passage of this act, employees were requesting off-work slips from their doctors for such extended periods that a committee of the Obstetrics and Gynecology Society met to put out suggested guidelines to physicians as to what were considered appropriate pre- and post-confinement periods for absences from work in uncomplicated pregnancy. Nothing is free and, to my way of thinking, such a law shifts the financial responsibility for caring for herself from the individual to society. If it were state policy to increase the birth rate one might argue for this, but most people today seem to favor population control.

There was a time when society felt a man was responsible for a child he sired. Today, because abortion is legal, such responsibility is seldom invoked. With abortion legalized, another restraint on sexual promiscuity is removed, and ultimate responsibility for the result of such activity is decreased.

Development of Groups

Our country was developed by those seeking freedom. They were dependent on themselves for their future health, wealth and security. As

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our system has become more complicated and organized, we all belong to groups. Somehow it seems more difficult to hold groups responsible than individuals. If an individual calls in sick and says he cannot work, without much trouble the employer can determine if this is legitimate. But all too often recently, through the press and television, the public has been exposed to the farce of large numbers of a negotiating group pleading illness simultaneously. The spokesman for such a group denies this is a conspiracy of deception, but one must be naïve to accept such denials. Such an action obviously impresses negotiators with the solidarity of the group. The *Sunday Star-Bulletin Advertiser* of November 24, 1974, carried the heading "Sick-out at Prison Denied." The article quoted Val R. Cavaco as saying, "I don't know where the television and the papers are getting this and I didn't call it a 'sick-out'." The article went on to say, "On Friday, eleven were sick, five of them with industrial injuries. Some had been out a week to 100 days! And today, Saturday, nine are out, five are 'on industrial' . . ."

If five of nine were "on industrial," which requires a doctor's slip, only four were uncovered. To what extent doctors were pressured for such slips no one can say. The real facts of such an episode would require extensive study difficult to do because of the confidential nature of non-industrial reports. Suffice it to say, reporters were suspicious enough to make the charge.

Such action encourages the cult of non-personal responsibility. To further the interests of the group, the individual perverts the truth because acting as a member of a group, he accepts the cult of non-personal responsibility. The degree to which the individual can withstand the pressures of his group is a measure of the man. With group action necessary for change in present society, one can see that as the cult of non-personal responsibility grows, the need for insuring the responsibility of the group becomes greater.

Should Police Be Allowed To Strike?

This problem is well illustrated in the recent wave of strikes by government employees and most dramatically, the police. Jack Anderson, writing on the subject "Should Police Be Allowed to Strike," states:

"In several cities where we took soundings, the citizens can no longer be confident that they won't wake up one morning without police protection. More and more, cops are feeling that hard-line union tactics can work for them.

"Although only a few are willing to support an all-out strike, many have engaged in tactics that come close to walkouts. The 'blue flu'—large numbers of policemen calling in sick—

has been a predictable ailment in some cities when police salaries are being settled. 'Job action,' an American version of the British tactic of suddenly becoming a stickler for the rules, has also gained some ground, with policemen writing tickets for the most minuscule offenses to the detriment of more pressing matters."[†]

My concern over these matters is particularly heightened because, like it or not, my profession is saddled with the onerous task of completing the off-work slips, disability evaluations, social security forms, etc., etc. These forms are not always easy to fill out. Recently all physicians were notified by the State Department of Health as follows:

"Dear Doctor:

We wish to call your attention to a new law which goes into effect January 1, 1975, relating to certification for tax exemption for disabled persons.

In the last Legislative Session, Act 42 was passed, which changes the definition of 'person totally disabled' as found in Hawaii Revised Statutes, Section 235-1, so that instead of the very limited, categorical definitions now used ('Loss of both feet at or above the ankle,' etc.), the only criteria will be:

'A person who is totally and permanently disabled, either physically or mentally, which results in the person's inability to engage in any substantial gainful business or occupation.'

The Department of Health certifies to the disability on the basis of a written report by a 'qualified physician', so it is very possible that you will be approached for such a statement."

I appreciate this notification from the Department of Health. I also can anticipate the difficulties for all physicians when it comes to interpreting "substantial gainful business." I can see that the "league of disabled persons" will consider a doctor responsible if he goes to bat for the patient, but the state may equate responsibility with saving the State money. And, after all, what does "engage in any substantial gainful business" mean anyway? How about making "puka shell" leis, which sell for \$30 to \$100? The easier government makes it to be certified for tax exemption, and the looser the term, the fewer personally responsible people there will be.

Many of these forms most often submitted on behalf of the indigent or unemployed by law must be completed without charge to the patient. Most people are honest, but how do you evaluate the patient with fatigue, headache, or backache? The occasional insolence of some patients asking for off-work slips for periods long before the date of their first visit is some-

[†]Parade, November 17, 1974, p. 12

times astounding. When asked to obviously perjure myself on one occasion, I really wondered how far the patient felt he could manipulate a physician.

On the basis of my written report on a man with a chronic disease which I felt disabled him for his job, he was retired. I was astounded when within two months, he appeared in my office saying that the Personnel Department of the company where he formerly worked had told him that if he could get a slip from me saying he could work, he could draw unemployment benefits for the next 26 weeks. He was not happy when I refused.

Government Programs

The extent to which many government programs have been broadened over the years by liberal interpretation to me completely changes the original intent of the law. The further government provides for all the needs of a person, the less he tends to fend for himself and take personal responsibility for his welfare. Workmen's compensation laws developed in many states between 1902 and 1917 to meet a real need. In many countries this was the first type of social insurance legislation enacted. By 1960, the annual cost of workmen's compensation to employers in the United States had increased to about 2 billion dollars. Early laws covered only disability from accidents. Later, disability from occupational diseases and accidents to and from work were included.

The broadening of this concept to include illness occurring during working hours or illness which might be caused by stress of work has enormously broadened the original concept. Maybe this is just getting us ready for national health insurance because in Britain, the workmen's compensation acts were repealed as of July 5, 1948, when the national insurance scheme came into operation. The Beveridge report of 1942 advised the abolition of the separate scheme of workmen's compensation. In the new system in Britain, industrial injuries were still handled differently from other injuries. At least when we get national health insurance in this country, there should not be the pressure to expand the scope of workmen's compensation coverage just to get the cost of the patient's medical care covered by some form of non-personal insurance.

Workmen's Compensation in Hawaii

Hawaii has had a workmen's compensation law since 1915 and the benefits have been steadily broadened. Section 386-3 of Hawaii's workmen's compensation law states:

"If an employee suffers personal injury either by accident arising out of and in the course of the employment or by the disease proximately caused by or resulting from the nature of the employment, his employer or the special

compensation fund shall pay compensation to the employee or his dependents as hereinafter provided."

Some examples of the extent to which the law has been broadened dismays many doctors. A middle-aged man suffers a stroke in the early morning hours. He is hospitalized for some days, then is off work for some weeks until he essentially recovers. His medical insurance pays most of his bills and today he would receive temporary disability payments as well. One's records are closed. Then months later he returns to say his employer feels he should file for Workmen's Compensation because for some period prior to his stroke, he was doing the work of another employee who was on vacation. If a doctor doesn't cooperate and send reports to the Bureau, he will be ordered to do so. This patient's illness is determined to be compensable by the Bureau, so all charges are recomputed and somehow it is all adjudicated.

As with any decision, if the parties don't agree the lawyers take over, and our Supreme Court ultimately interprets the law. A middle-aged man doing his usual work moving 15 to 20 pounds of cargo collapsed and was dead on arrival at a hospital. No autopsy was performed. The death certificate listed acute coronary insufficiency. The Labor and Industrial Relations Appeals Board denied a claim for Workmen's Compensation reasoning that death was due to cardiovascular disease of long standing and not attributable to his employment. This was in line with a case tried in 1967 where the Court had held that:

"Work activity for which the individual is accustomed over a long period of time has no relationship to the coagulation or clotting of the blood and that...death-producing coronary thrombosis resulted independently from the work, from the natural, inexorable and progressive march of his pre-existing coronary heart disease."[†]

This makes sense to most doctors.

But in the case described above, our Supreme Court in a three-to-two decision reversed the decision of the Appeals Board on the basis that the employer had not produced "substantial evidence that it (death) is unrelated to the employment activity." Obviously a non-lawyer finds it difficult to understand the fine points of the law, but the Court went on to say:

"In its wisdom in formulating public policy in this area of the law, the Legislature has decided that work injuries are among the costs of production which industry is required to bear; and if there is a reasonable doubt as to whether an injury is work connected, the humanitarian nature of the statute demands that doubt be resolved in favor of the claimant."^{††}

[†]Civil 20952

^{††}No. 5096

To me a possible heart attack in a person doing his usual job is difficult to classify as an injury. But again, the Court would answer this argument by another quote:

"But while it may be sound medically to say that the work did not 'cause' the attack, it may be bad law, because in general, existing law treats the slightest factor of aggravation as an adequate 'cause'."

When I told a lawyer friend that this ruling seemed (as the young people would say) "way out," he replied that, "The only way this decision can be understood or justified is strictly on a socio-economic philosophical basis."

The social planners and schools of public health tell us we should educate the individual to be more responsible for his health. This kind of decision would suggest the individual doesn't need to worry; his employer will pay.

This just means that from 1967 to 1972 philosophically the cult of non-personal responsibility has taken a giant leap forward. An honest physician who denies a patient's request for sick leave or any other benefits can really be harassed by our system.

Welfare

Much has been said and written about the public's right to medical care and Senator Kennedy thinks he knows how the government can deliver this. Many are worried about the cost. Now we read in the *Star Bulletin* of September 9, 1974, that:

"Several welfare mothers filed a suit in federal court Friday demanding that the State be required to pay them welfare benefits for which they received approval."

I will have to leave the legality of this one to the lawyers but it certainly suggests that welfare payments are a right; it is just a matter of how much and how soon they need to be paid.

The *Sunday Star-Bulletin & Advertiser* editorial of December 1, 1974, on "welfare reform" said that one of the problems of the present welfare system is that:

"It discourages work, since those who would be paid near the minimum wage could net less than what they forfeit in welfare benefits."

The present welfare system certainly furthers the cult of non-personal responsibility, and if the individual has any pride the cost to him in loss of self esteem could be disastrous to the point he no longer tries to work and be self sufficient.

As practicing physician who has worked for years in many government-funded clinics, I have great compassion for those destitute through no

fault of their own. Society owes such persons the best life it can afford to give them. The problem, as usual, lies in motivating those who can—but choose not—to pull their share of the load: namely, the voluntarily unemployed.

Responsibility in Medicine

Changes in feelings of responsibility among physicians-in-training today are prevalent and we can be sure this will be apparent in the delivery of medical services in the future. Changes have been going on for years and were accelerated during the war. There was a time when Dr. Harvey Cushing, the eminent neurosurgeon, would not accept a resident for training if he was married, for fear he would not devote full time to his patients. Persisting through my years of internship and residency training was the idea that we doctors were responsible for our patients twenty-four hours a day and seven days a week. We received board, room and laundry for our efforts as residents, which were 16-18 hours of work a day, seven days a week. One of my friends tells of walking into the hospital to start his internship. He was given a uniform and put to work, and he claims it was a month before he got outside to unpack his car. If one's work was done and his records complete, he might get every other Sunday afternoon off. It was a stimulating life, but much of the work was routine drudgery, which was service to the hospital. By present day standards we were grossly exploited by the hospitals—but hospitals don't make money, and if we had not done the work free, rates would have been higher. Nurses and other hospital employees in those days were underpaid and worked long hours, but somehow one was respected by most people and not considered stupid. The rapidly escalating cost of hospital care today is in considerable degree due to labor costs, which account for over 65% of hospital costs. Wages in hospitals are only catching up to those on the outside over the past two decades.

I was dumbfounded to learn recently that a residency a friend of mine was starting gave him three out of four nights off, and the day off after he was on call during the night. He was also getting a thousand dollars a month income, which for his age and years of training is not excessive, but it is different than it used to be. For one trained in the old system, there is something to be said for spending a few years literally at the patient's bedside night and day to follow the course of disease.

Mary C. Howell, M.D., Ph.D., made a study entitled "Patients and Family: What Does Responsible Mean? The Supply and Demand of Flexible Time Programs in Graduate Medical Education." She comments that, "Today's physicians-in-training are not as willing as their

predecessors to resign themselves to the treadmill of postgraduate medical education." Her article in November, 1974 issue of *The New Physician*, entitled, "Stop the Treadmill . . . We Want to Get Off" summarizes her studies. The studies indicate a rather marked difference in opinion between program directors and students relative to flexible training programs. Almost three-fourths of students said they would choose a less desirable location if they could enroll in a flexible time program, but only 15 percent of the directors of postgraduate programs said they would be willing to consider offering such programs. Sixteen percent of training directors said they would be more willing to provide flexible scheduling for women than men, yet 59 percent of men and 85 percent of women expressed interest in flexible time programs.

Quoting from Dr. Howell, "The desire to live a full life, to live and stay sane," were reasons for wanting flexible time programs. The students envisioned working 40 to 60 hours a week. To some older doctors and medical directors such comments are heresy.

In her sampling, only 11 percent of the programs require a work week of 59 or fewer hours. Only surgical residencies required over 120 hours per week.

Dr. Howell concludes her article by noting that the need and demand for such programs is growing and she feels ultimately patient care is harmed when young physicians are asked to choose medicine instead of life.

Medical Practice

Younger physicians trained in programs requiring fewer hours per week are unlikely to accept round-the-clock calls from patients, and already in the past few years we have seen the development of a new type of physician, the emergency room physician. This group has developed to staff the hospital emergency rooms because interns and residents give less service time to hospitals, and hospital staffs are more reluctant to cover emergency rooms; also, patients previously seen in offices are now often seen in emergency rooms. The number of visits here is soaring.

From the patient's standpoint, it means he is less likely to see his usual doctor in emergencies. From the hospital's standpoint, it means a new category of staff to assimilate. This is not all bad and the complexities of emergency medical care make it something probably better handled by those with special training. The example is used, however, to indicate how time and progress have changed earlier concepts of the one-to-one feeling of responsibility by a doctor for his individual patient. Patients, while they decry this change, have done a great deal to bring it about by their frequent flitting from specialist to spe-

cialist depending on which specialist they think is best able to handle their latest complaint, rather than sticking to their personal physician who knows them and who in a fraction of the time and at far less cost can diagnose and properly treat the majority of their symptoms.

Physicians, as a rule, tend to be independent, and they must be able to make individual judgments. They have tended to band together in professional societies but until recently have not formed unions. But the *AMA News* of October 14, 1974 states:

"The Physician National Housestaff Association moved a step closer to forming a national union for interns and residents at the group's second annual National Assembly in Kansas City on October 4-6."

The old often follow the lead of the young these days, and it probably is significant that our speaker at the Honolulu County Medical Society on December 10, 1974 was Dr. Sanford A. Marcus, President of the Union of American Physicians, headquartered at the World Trade Center in San Francisco. Dr. Marcus feels doctors are naive to cooperate with government in forming a Professional Standards Review Organization, and that the only hope for doctors in the economic field in the future lies in a strong union and collective bargaining. The experiences of some of our brethren in foreign countries suggests he may be right. Doctors in other countries have struck to obtain proper working conditions. It will remain to be seen how American physicians will handle their responsibility to patients if working conditions ever become intolerable. Certainly past traditions of medical practice have caused the ethical physician to work extremely hard and given him a stern sense of responsibility. Much of this drive was due to his ability to run the show. As government attempts to plan, control, regulate and run the show, the feeling of personal responsibility becomes eroded.

Nelson Doi in his inaugural address was concerned about the lack of voter turnout as a sickness in our society. He stated "It has been called many things; alienation, apathy, indifference . . ."

To me, this is talking about responsibility and, as indicated by what has gone before, the sense of responsibility in medicine was extreme. Dr. Howell, as quoted earlier, said she feels ultimately patient care is harmed when young physicians are asked to choose medicine instead of life. To many in our present affluent society long hours of hard work seem to be unfair and unhealthy. Everything is relative and those growing up in the early thirties may have a different attitude than those growing up today. I guess I tend to agree again with Dr. Szasz who wrote in *The Second Sin* that "the greatest analgesic,

soporific, stimulant, tranquilizer, and narcotic—in short the closest thing to a genuine panacea—known to medical science is work.”

It helps to be able to do the kind of work you like, and control the terms under which you will accept responsibility.

In any case, the sense of responsibility is changing and to the extent physicians work shorter hours, it will take more bodies to do the work and this means more doctors or more paramedical personnel which is the latest solution to the alleged manpower crisis in medicine.

Conclusion

Government, by supplying all of a man's needs without doing anything to encourage personal responsibility (which psychologists tell us is important for the growth of the individual), encourages the cult of non-personal responsibility. This cult goes along with the so prevalent attitude of complete individual freedom of letting each individual do his own thing, which is great—but someone else picks up the tab and has to pay for those who cannot or will not pay their own way. No one objects to helping those in distress, but finally there seems to be concern that the system needs to be reviewed. Our culture has been unfair to minorities in the past but seems to be trying to correct the situation. Our system should not, because of past mistakes, go overboard and ask no personal responsibility of our citizens. As Dr. Szasz put it “Punishment is no longer fashionable. Why? Because—with its corollary, reward—it makes some people guilty and others innocent, some good and others evil; in short, it creates moral distinctions among men, and, to the ‘democratic’ mentality, this is odious. Our age seems to prefer a meaningless collective guilt to meaningful individual responsibility.”

In a November editorial in a Carolina newspaper entitled “Dumping the Drones”, the writer suggests the country can no longer support multiple non-productive members. Dr. S.I. Hayakawa, in his November 16 *Star-Bulletin* article on “Motivating Young Workers,” quotes Daniel Yankelovich, a leader in public opinion research, as follows:

“Today's non-college youth, like their college counterparts, tend to take somewhat for granted good pay, a mounting standard of living, and economic security. Like their college peers, they have taken up the quest for a new definition of success which stresses personal fulfillment and quality of working life...”

Dr. Hayakawa goes on to quote Dr. Berger, professor of sociology of Long Island, writing in “The Public Interest” that there is “a growing expectation among young people that work should be meaningful.” These authors, recog-

nizing that this rising demand for interesting and exciting jobs is outrunning the supply, then suggest that the government will have to invent such jobs in what they call “people work, services for the young and old.” It is recommended that the programs be administered wherever possible at the local level rather than the federal and that there has to be “moral conviction about the goals of the activity and moral commitment to the work involved.”

As Dr. Hayakawa concludes, “In the present state of the culture, these are difficult prescriptions. How do we change directions away from reliance on Washington? Where are the moral convictions and commitments going to come from?”

These quotations suggest to me that others are concerned that trying to spoon feed the populace is a bankrupt policy and that a return to personal responsibility is overdue.

The debate entitled “Social Security: Universal or Selective” was published in 1972 by the American Enterprise Institute for Public Policy Research. Wilbur Cohen, former Secretary of Health, Education and Welfare, spoke for Social Security. Dr. Milton Friedman, professor of economics at the University of Chicago, spoke against. The preface quotes Dr. Friedman as saying, “The fundamental issue is: As we look toward the future, do we want our society to develop in such a way that individuals separately will have greater responsibility, or do we want it to develop in such a way that the collective entity is more dominant and more omnipresent?” This suggests to me that Dr. Friedman would say the Social Security system fosters the cult of non-personal responsibility.

Jack Anderson's column is never an antidote for ulcers, and his message, “Social Security Troubles,” in the November 14 *Star-Bulletin* is no exception. His facts suggest troubles ahead. Some excerpts are as follows:

“Social Security payments come out of current taxes on those who work. Thus, they depend on the continued willingness of active workers to pay. In 1950, there were 12 working taxpayers for every retired recipient; thus the bite out of each worker was painless. By 1960 that ratio had fallen to 4 to 1. It is now down to 2.5 to 1. In 1950 the maximum Social Security payroll tax was \$45 a year. Next year it will be \$841. The tables on which Social Security income and outgo are figured assume an economy in which wages rise 5 percent and inflation is no more than 3 percent each year.”

Mr. Anderson concludes his report by saying,

“If this system is to continue its great and indispensable work, officials responsible must face the truth, tell the truth and treat the retirement program of 100 million Americans

as responsibly, say, as if it were their own."

My aim was to demonstrate that concepts of responsibility have changed with the years, and I meant all categories of responsibility, namely

solvency, duty, and trustworthiness. I have labelled the change as a cult of non-personal responsibility. I have tried to show by quotes that others are increasingly apprehensive about the changes occurring.

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H. TOM THORSON

AMA will continue into early 1976 the free distribution of specialty journals and Today's Health.

FAA has proposed regulations allowing pilots to wear contact lenses. Some ophthalmologists may object. Written comments may be filed with the FAA referring to 14 CFR Part 67, Docket 14971.

AMA Pushing For End To Rulemaking Abuses By HEW. A bill is being backed that would provide adequate time to respond and comment on proposed regulations and restrict the use of contract directives or transmittal letters to modify procedural matters. Other bills would refer regulations to congress before becoming final.

Some examples:

HEW UR regulations recently outlawed through court action by AMA. Economic-index regulations on physician reimbursement under Medicare without time for response.

FDA publication of administrative procedures considered final on day of publication and against which a preliminary injunction was granted.

HEW publication of final rules for a state seeking a rate-setting grant under the planning act although no rules had been published. Publication on October 17—with 30 days to comment—of proposed rules for health system agency under the planning act.

HMA will submit a letter of intent to file as a Health Systems Agency under the planning act (93-641). The exact form of the HSA under HMA is yet to be determined. Committee will be chaired by Dr. Cal Sia. The AMA is challenging the constitutionality of 93-641.

Unified Membership—The states of Kentucky, Pennsylvania, and Virginia have voted to instruct their bylaws committees to prepare amendments to provide for unified membership.

Malpractice Insurance Update—Work is progressing on the writing of the omnibus bill.

First public hearing has been held on the rules and regs for the Joint Underwriting Plan.

Notes—Total premiums from physicians, dentists and hospitals have gone up 3,200% in fifteen years and it is predicted that the average increase in the next year will be about 100%. These are national figures and hopefully we can shade this by a substantial amount in Hawaii.

Hawaii Medical Library Benefit performance by Sammy Davis, Jr., December 26, 1975 will be a gala evening at the Coral Ballroom, Hilton Hawaiian Village Hotel. Tickets for the performance and dinner are \$100. Of this amount \$75 is tax deductible. Proceeds will be used to assist the library to retire its debt. This is a major project of the Auxiliary to the Honolulu County Medical Society and is designed to benefit the entire community. Buy your tickets now—sell some to your friends!!!

AMA Meeting, starting November 30, 1975, will feature continuing education programs. A full schedule is in the October 13, 1975 issue of JAMA. It is not necessary, but desirable, to register in advance. Members may register at the meeting. For members from out of town, please communicate with Trade Wind Tours if you need rooms. Their phone number in Honolulu is 923-2071.

Postal Rates to rise by thirty percent the first of the year on all first class mail.

Medical Licenses will be issued on a biennial basis beginning January 1976. Fee for a two year license will be \$15.00.

Social Security deductibles to rise beginning in 1976. Part A (inpatient hospital) deductible will go to \$104.00, from \$92.00, for the first 60 days with daily deductible thereafter of \$52.00.

EMS Seminar—November 17-20 at Kaiser Hospital. All physicians are welcome. For further information call 538-9011 (Queen's) and ask for extension 471.

HMA House of Delegates—Full details will be published in the December JOURNAL but some of the items of immediate interest are:

1. Reaffirmed the unity membership concept.
2. Created a Commission on Continuing Education.
3. Gave top priority toward the obtaining of a new home for HMA.
4. Instructed the Council to move toward implementation of the "Dang" plan for funding future developments.
5. Did not change the dues for HMA.
6. Instructed the Foundation for Medical Care to explore the possibility of becoming an HMO.
7. Created a new committee on Sports Medicine.
8. Directed the drafting of legislation to provide for proper reimbursement for care of medicaid patients.

A number of other items were acted upon by the House of Delegates and full details will be in the next issue.

Opportunities—

Family practitioner in Aiea area seeking an associate. Call Dr. Cahill—phone 488-3752.

Faculty position—U of H for Ob/Gyn with special training in peri-natal medicine—Board certification or eligibility required—Call Dr. Ralph Hale—School of Medicine.

Medical Officers—Pearl Harbor—Naval Regional Medical Clinic—Involves shift work and weekends and includes duties of medical officer in outpatient system. Contact—Consolidated Civilian Personnel Office, Naval Station, Pearl Harbor, 4300 Radford Drive, Honolulu 96818.

AMA Clinical—Starts November 30—opening of House of Delegates. All members are urged to visit the House of Delegate and reference committee hearings.

Remember—Get your Sammy Davis tickets for the Library Benefit **NOW!**

APOLOGIA ATQUE CORRIGENDA

Two major errors were perpetrated during the printing of "Madness in Paradise" in our August issue. The senior author, Stuart A. Kirk, D.S.W., was demoted to junior author, and the section on results was printed before the section on methods. To Dr. Kirk, who is now at the College of Social Professions of the University of Kentucky, we extend our apologies for these lapses.

HLAJR



Population Control, a la PRC.

The People's Republic of China must have a population of some 900-million and probably precisely uncountable (the census takers must never be able to keep abreast of the tally!). A 2% annual increase means 18-million new mouths to feed, and this requires 5-million more annual tons of food grains.

An article: "Agriculture in China," in the June 1975 issue of *Scientific American*, not only reveals interesting perspectives into how the PRC deals with problems of increasing food production, but it also provides us with food for thought. Incidentally, its author is Sterling Wortman, Ph.D., vice-president of the Rockefeller Foundation and formerly with Hawaii's Pineapple Research Institute.

The PRC has had to do more than increase its agricultural production in order to feed its millions; it has had to tackle the problem of its expanding population as well. In this regard, Dr. Wortman has some interesting observations:

China's population being overwhelmingly rural, the government's efforts have been primarily focused on the farm labor force.

Production teams in the communes are made up of household units. The costs of production take up 30% of the income; 11% goes into capital re-investment; 4% is paid to the government in taxes; 3% is placed in a welfare fund for the care of "new mothers and the elderly" (non-work force), and the remaining 52% net income is divided up—the fewer, the more each person gets to keep. "Such a work-point system . . . provides a strong incentive for increased overall output . . . at the same time it encourages householders and production teams alike to keep their numbers from increasing . . ."

Secondly, improved health care has greatly reduced infant mortality. The traditional view that

many births are needed to ensure the survival of even one offspring to maturity is therefore succumbing to this realization. Likewise, custodial care of the elderly by means of the 3% welfare fund is undercutting the traditional concept that multiple births are necessary to ensure adequate support for the aged—a personal sort of social security.

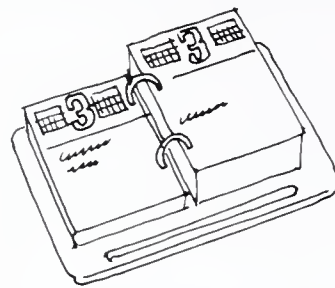
Finally, the commune system established in the 1950's has allowed 5 to 7% of the arable land to be parceled out as private holdings, but only one share to each adult in a household and to each of the two oldest children. A large family gets no additional shares. Now, nearly a generation later, this system may be exerting a powerful effect in terms of decreasing the family's birth rate.

This is an aggressive and coordinated effort on the part of their society. There is reason to believe that it is more of a "gung-ho" attitude on the part of its members in unison, rather than the punitive oligarchical governmental pressures of the Soviets in the USSR. However, no one can be certain that Chinese "human nature" may ultimately result in rebellion against this form of autocracy as against the soviet form. The power of suppression inherent in the apex of the Soviet bureaucracy is practically irresistible; the winds of change in a huge "unified" society are more likely to exert an effect on the whole.

In terms of our own society in which freedom of thought and action of the individual is paramount, the Chinese society appears to be incomprehensible and unattractive, although there are many "do-gooders" who would love to see this country so socialized. However, the PRC approach to the problem of overpopulation, which problem has excited many in our country too, is worth considering.

As Dr. Wortman concludes: "Only if this policy meets with success will the Chinese people continue to receive the benefits of increased agricultural production and the accompanying advances in living standards that so many of China's people now seem to expect."

J.I.F.R.



Continuing Medical Education

CME News

The Clinical Session of the American Medical Association will begin in Honolulu on November 30. Advance registration is encouraged: please write directly to the AMA, 535 North Dearborn Street, Chicago, Illinois 60610. Full details of the scientific program are listed in the October 13 issue of JAMA. The House of Delegates convenes at 10:00 a.m. on Sunday, November 30 with reference committee hearings on Monday beginning at 8:30 a.m. at the Sheraton Waikiki. The delegates will reconvene for House action on Tuesday at 10:00 a.m. and Wednesday at 8:30 a.m.

We are pleased to inform you that the continuing medical education program of the Hawaii Medical Association has been granted full approval by the Council on Medical Education of the AMA for four years.

CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS:

Ongoing

Kaiser Hospital

(Contact CME Dept. for further information)

Kauaikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program



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- Kapiolani Maternity Hospital
1. Tuesdays—CME Program, 1:00-2:00
 2. Grand Rounds, Wednesdays, 7:30-8:30
 3. Visiting Professor Program (see Special Events)

- Kuakini Hospital
1. Hematology Rounds, Monday, 1:00-2:00 p.m.
 2. Gastroenterology, Tuesday, 8:00-9:00 a.m.
 3. Oncology Conference, Thursday, 8:00-9:00 a.m.
 4. Endocrine Conference, 2nd Wednesday each month, 1:00-2:00 p.m.
 5. Medical Statistics, 3rd Tuesday each month, 1:00-2:00 p.m.

- Wilcox Hospital (Lihue)
1. Department of General Practice Meeting—last Wednesday
 2. General Medical Staff Meeting—2nd Tuesday
 3. Clinical Review Meeting—Alternate Mondays at noon
 4. Tumor Conference—First Thursday

SPECIAL EVENTS

- November 29- American Medical Association, 29th Clinical
December 5 Convention, Sheraton Waikiki, Honolulu.
Contact: Frank A. Gray, AMA Convention,
Services Department, 535 N. Dearborn
St., Chicago, Illinois 60610.
- December International College of Surgeons, U.S.,
5-9 Section Annual Meeting, Sheraton Waikiki,
Honolulu. (A preliminary program is in the
HMA office.)
Contact: Mary Lento, PRC, International
College of Surgeons, 1516 Lake Shore
Drive, Chicago, Illinois 60610 or HMA
(CME Office)
- December Cleveland Academy of Medicine, Kona
5-11 Surf/Sheraton Maui
Contact: Donald Mortimer, 10525 Carnegie
Avenue, Cleveland, Ohio 44106.

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- January Prenatal Medicine; USC at Royal Lahaina,
17-24 Maui
- January 18 Medical Emergencies in the Elderly, pre-
sented by the American Geriatrics Associa-
tion and the HMA, to be held at Straub
Clinic, 8:30-4:30. Speaker: Thomas Criley,
M.D.
Contact: L. Clagett Beck, M.D., 523-2311.
- February Surgical Diagnosis and Therapy; The Phil
7-14 Thorek Postgrad Courses, 850 W. Irving Pk.
Rd., Chicago, IL 60613 at Maui Surf Hotel,
Maui; fee: \$300.
- February Sports Medicine for Primary Physicians;
15-19 Kuilima Hotel, Oahu; contact: Joy Lewis
(for Dr. Richard Strauss), University of
Hawaii Conference Center, 2500 Dole
Street, Honolulu 96822.

- February 23- Practice Management for the Health Team;
March 1 Medical Computer Services Association,
315-1107 NE 45th, Seattle, WA 98105; at
Kauai Surf Hotel, Kauai; 20 hours credit.

OUT OF STATE:

American College of Physicians; regional meetings and pro-
grams as scheduled below:

- | | |
|----------|--|
| December | Winston-Salem, North Carolina |
| 4-5 | |
| December | San Antonio, Texas |
| 4-6 | |
| December | "Fluid & Electrolyte Balance, Hypertension |
| 8-12 | and Renal Disease" at Chicago, Illinois |

For further information: American College of Physicians,
4200 Pine Street, Philadelphia, Pa. 19104.

- December 1-2 JCAH Workshop on Long Term Care at
Nashville, Tennessee.
Contact: Mr. Bob Loflin
Tennessee Hospital Association
214 Reidhurst Avenue
Nashville, Tennessee 37203
- December 4-5 "Phenomenology & Treatment of Depres-
sion" at Shamrock Hilton Hotel, Houston,
Texas; 15½ hours credit; fee: \$150.00.
For more information, contact:
Office of Continuing Education
Baylor College of Medicine
Texas Medical Center
Houston, Texas 77025
- December CPHA Quality Assurance Workshop at
17-18 Dallas, Texas. Contact:
Commission on Professional & Hospital
Activities
1968 Green Road
Ann Arbor, Michigan 48105

1976

- February "Pulmonary Function in Health & Dis-
16-18 ease," "Pediatric Pulmonary Disease" and
"Newer Concepts of Care for Patients with
Respiratory Disease" at Braniff Place Hotel
in New Orleans.
For more information contact:
American Thoracic Society
1740 Broadway
New York, NY 10019
Attention: Mr. Ben Fontaine
- February Diving Medicine at Truk, Micronesia; fee:
23-28 \$200. For more information contact:
University of Hawaii Conference Center
(DMC-76)
2500 Dole Street
Honolulu, HI 96822

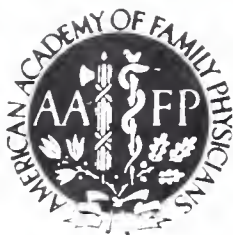
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Hawaii Academy of Family Physicians' Newsletter

J. I. FREDERICK REPPUN, M.D.

NEW MEMBERS—Ben K. Azman MD is a new Active member located in Lahaina, Maui; we were delighted to see him seated as a delegate to the Hawaii Medical Ass'n annual meeting in October. New Student members are: **Kevin B. Kunz**, UHSM II, and **Sandra Penn**, of the same class. Welcome!

DROPPED—from membership or resigned: **Robert Kranz MD '75**—reportedly defecting to the ranks of the Specialists—anaesthesiology. **Col. Bill Brownlee MC, AUS**, has retired and moved to Colorado.

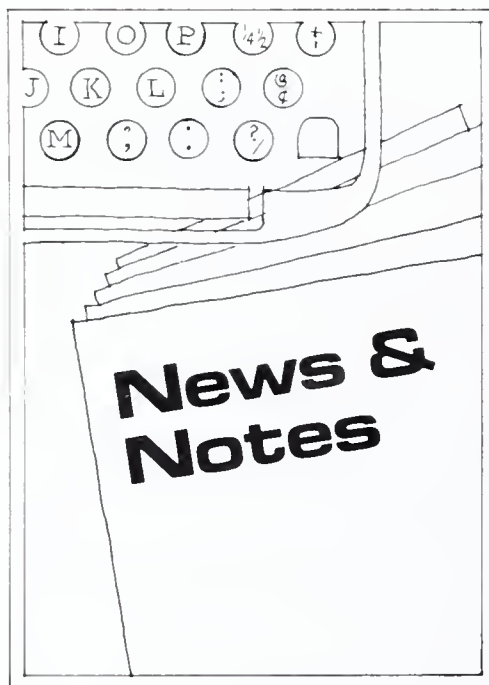
REQUIEM—we were sorry to read of the passing of **Harold Machigashira's** father at an advanced age. Condolences to Harold.

NEWS of MEMBERS—**Doris Jasinski** gave Hawaii an aura of singular beauty when she figured in the Assembly Reporter of 6 October published daily for those who attended the 27th annual meeting in Chicago. **Felix Lafferty** gets the credit for the photo of Pres. Herb Holden installing our beautiful Chapter President last December. Speaking of photos: A large one in color graced the walls of the alley leading to the general lecture hall at the McCormick Place Convention Center—of our **Bob Bell**, richly bearded and regally capped and gowned for receiving his Fellowship degree. The photographers were advertising and could not have picked a better "mug"! The Hawaii contingent at the AAFP meeting in Chicago included: **Bell, Lafferty, Reppun** and **Wentworth**. Doug Bell Senior was there—not a member but a long-time GP in Hawaii. If any other members were there and lost in the 3,622 physician registrants and the 7,451 total registrants, please let us know.

The 1975 CONGRESS of DELEGATES—in Chicago (of which **Lafferty** and **Reppun** were two out of 112): weaseled on Public Law 93-641 by "urging Academy members to become involved in implementation of the Act at the state level." This is, of course, impossible, since physicians are generally frozen out of any participation at any level. However, the Academy will work towards modifying the law; approved a set of guidelines on medical malpractice insurance but deferred to the AMA on implementing policy; spoke in favor of "buy out" provisions in the Health Manpower legislation pending, to allow students with scholarships to get out from under if they wish; opposed student paybacks in exchange for capitation fees to medical schools, nor that students MUST practice in specified areas as a price of the school obtaining a grant; supported equal fees for equal service in underserved areas; encouraged Academy efforts to influence the JCAH to modify its rulings on Family Practice Departments; encouraged the Academy to develop new methods of demonstrating physician competence; streamlined membership categories; etc.

HMA ANNUAL MEETING, the 118th—it was great to see new member **Ernest Bade MD** of Hilo as a seated delegate. It was gratifying to hear the names of so many GP's and chapter members read at the annual banquet by Pres. Win Lee, honored as members of HMA for 40 or more years. It was great to say hello to 24-year member **D.L. Burlingame MD, HAFP** Inactive, now of Kamuela, Hawaii. Don and Mrs. were greeted by many friends. Our **Varian Sloan** served masterfully as M.C. at the banquet.

J.I.F.R.



HENRY N. YOKOYAMA, M.D.

Life in These Parts

At the October ACS (American College of Surgeons) meeting in San Francisco, Hawaii's own, **Richard Mamiya** demonstrated a new operating procedure in a Davis & Geck 20-minute film, "Coronary Artery Bypass." In the film, Dick does a quadruple coronary artery bypass for angina using saphenous veins, internal mammary artery, sequential bypass, and local endarterectomy . . . (Damn good for a local yokel . . .)

We received a personally autographed copy of **Kazuo Miyamoto's** latest: "Vikings of the Far East," fresh off the Vantage Press. The book climaxes 20 years of research (mostly from Japanese publications) on the "Wako" (Japanese pirates) who like their western counterparts ravaged the Far East and played a prominent role in the economic, social, and political history of the area. Kazuo's other publications include "A Nisei Discovers Japan," "Glimpses of Formosa and China Under Japanese Occupation in 1939" and his most famous, "Hawaii, The End of the Rainbow" (which is also available in paperback) (Methinks this physician is busier than ever since his retirement from practice)

A 73-year-old Japanese patient with a long history of diabetes, HCVD, and ASHD, and repeated admissions for CHF, cardiac arrhythmias, and recurrent MI's, looked to be in the pink of health. We asked what his secret health formula was. He beamed proudly as he explained that he had been doing the alternating hot and ice cold tub baths prescribed by the Nishi Health System for the past 10 years, and resumed them immediately upon discharge from the hospital each time. We gently admonished him for such a hairbrained stunt, and he promised to stop . . . Two weeks later, he died even with an emergency pacemaker installed . . .

When the Center for Disease Control in Washington, D.C. reported on anisakian larvae being coughed up by mainlanders eating raw fish, our Mauians poohpoohed the report. **J. Oblon** of our local Center for Disease Control reported that

only seven cases of worm infestation from eating sashimi and other forms of raw fish had been reported in the U.S. out of a population of 210 million . . . One Maui sashimi veteran remarked, "Yeah, there's worms in aku, certain time of the year. They look like little white spots in the belly of the fish. I just cut that part out and give it to my cats." Another sashimi eater remarked, "After five beers you can't see them anyway . . ." Public health specialist **Bob Okawa** said, "I've never heard of any problems of worm infestation in Hawaii . . . though certain fish do carry various kinds of parasitic worms . . . (So much for wormy sashimi . . .)

On the Big Island, district health officer **Andrew Sackett** reports that the skateboarding accident rate has decreased considerably with the beginning of school, but the rate of injuries was still excessive. The survey showed that the rate of accidents is 2 or 3 times higher during the summer months . . . (The orthopods should buy shares in skateboard manufacturing firms . . .) [or vice versa—ED]

We are happy to see that **Robert Moser** has resumed his "Materia Medica" column in *The Maui News* . . . We have always marveled at his ability to discuss medical subjects in simple lay language, an ability most of us unfortunately lack . . . In a recent *Materia Medica* article on hypertension, Bob wrote, "We have wonderful potent medications that can bring the pressure down to satisfactory limits and prevent the unfortunate consequences (re: strokes, kidney and heart damage) . . . An additional major problem is that the medications, which must be powerful to counteract hypertension, often cause unpleasant side effects. Most of these can be prevented or eased by juggling doses or changing medications . . . But it takes time and perseverance—with doctor and patient working as a team to tailor a program of drug therapy that will control the pressure and keep the unpleasant effects of the drugs to a tolerable minimum . . ."

A week later, a "Health Conscious" ignoramus wrote in the *Maui News* Community Forum thusly: "No doubt the good doctor means well advising people to take strong medication—even if it has unpleasant side effects—for the rest of their lives to ward off high blood pressure. Most doctors in this country are influenced by the chemical industry who produces and makes profits on all medication (Editor's note: Bob is one of the outspoken authorities on drug interaction . . .) . . . Little effort is made to remove the cause of disease . . . You will note that Dr. Moser does not even hint in this direction . . . The truth is that most people with high blood pressure are just paying the price for unhealthy living habits, faulty nutrition, smoking, drinking, overeating, lack of exercise. Instead of taking medication, they should alter their living habits and get rid of the conditions that cause their high blood pressure in the first place . . . There are a few courageous physicians who refuse to meekly follow the procedure sponsored by the chemical industry and dictated by the AMA, and they are publishing books on their findings and their recommendations . . . I just want to mention this so that the unhappy sufferers of hypertension can see a ray of hope, and study such books that will show them the alternatives to dependence on harmful medication . . ."

Dammmest Dang'd Dialogue

Memorandum to **William Dang** re: "The Site Plight"
From **Rowlin Lichter**

(Editor: After the Dang Plan was adopted by the House of Delegates)

"Deep deliberation detailing descriptive date demanded 'Dang's Ding.' 'Duped!' doctors declared, 'Don't drop dough dubiously.' Digging deep, 'Danged, Dang's Ding' distressed disturbed diligent doctors dubbing 'Dang's Ding'—'Dang's Ding-a-Ling Ding.' Deemed diddle, delegates' dollars disappeared. Disseminated, discussed, dissected, dismissed. Dang's Ding did 'dat dispell. Dang's Ding did do!"

To: **Rowling Lichter**

From: **William Dang**

"Dammm delicate deliberate dissertation!"

Professional Moves

We apparently misplaced and failed to report the following announcements: In July, **Jon Callan**, pulmonologist, joined the Honolulu Medical Group; on Kauai, GP **Robert Freeman** and pathologist **Rex Couch** joined the Kauai Medical Group; and on Maui, dermatologist **Gary Salenger** joined the Maui Medical Group. In August, OB man **Gordon Ontai** opened at Suite 438 Professional Center Building, and psychiatrist **William Cody** and OB man **Leonard Howard** associated with the Hawaii Permanente Medical Group. (Our apologies to those mentioned above . . . No one has ever complained, but if we have missed others, please notify us, rather than stew in sullen silence . . .)

On to October: internist **Wilbur Lummis Jr.** joined the Dickson-Bell Medical Center, neurosurgeon **William Hammon** joined the Straub Clinic, internist **Conchita De Castro Redmon** joined the Medical Arts Clinic in Wahiawa, eye man **Calvin Miura** opened at 641 Keeaumoku, and OB man **Harry Wong** opened at 1282 Queen Emma Street.

A Retraction

We recently printed a humorous item written by our "roving eyes" reporter **Fred Reppun** who described a tee shirt emblazoned across the front: "Milk and Cream" and worn by Sharon Bintliff at **Marc Schlacter's** wedding. Sharon confronted us to straighten out the facts in the item: Firstly, that she was not at Marc Schlacter's reception, secondly, that her now famous shirt really says "Milk" over one breast and "Bakery" over the other; and thirdly, "Thank God Fred Reppun is still looking!"

Meetings and Announcements of Interest

Dick Blaisdell, chairman of the American College of Physicians Scientific Program reports that their Annual Regional Meeting will be held in Honolulu at the Pacific Club on Mar. 9 and 10, 1976. Physicians, houseofficers and fellows are invited to submit abstracts for scientific papers to be selected for presentation. Abstracts should be 200 words or less, are due Dec. 1, 1975 and may be addressed to: R.K. Blaisdell, Chairman, Scientific Program, American College of Physicians, UH Department of Medicine, 3675 Kilauea Avenue, Honolulu, Hawaii 96816.

James Lumeng, Associate Professor of Pathology and Medicine, U of H School of Medicine and Associate Pathologist St. Francis Hospital announces that the Hawaii Society of Pathologists will hold a workshop entitled, "Recent Advances in Pulmonary Cytology" on Jan. 3, 1976 at Straub Clinic & Hospital Inc. Dr. Geno Saccomonno of Grand Junction, Colorado, will give the presentation."

Miscellany

Our HMA receptionist says, "If the government gets into many more matters concerning health, doctors or drugs, the President will have to appoint a **medicine** cabinet . . ."

An attractive girl sat alone in the cocktail lounge . . . A young man moseys over and offers to buy her a drink . . . "A motel!" she shrieks . . . "No, no . . . I said a drink," he says, embarrassed by the outburst . . . "You want me to go to a motel with you?" she yells louder . . . The other patrons stare and the young man flees to a dim booth . . . Several minutes later, the girl comes over, "I want to apologize, but I'm studying

psychology and I wanted to study the reactions of people here." Therewith the young man roars, "Seventy-five dollars!"

Three ministers of Israel were discussing their financial plight caused by the oil embargo. One of them suggested, "Why don't we declare war on America. Then when we lose, we can get lots of money . . ." That's a good idea . . ." agreed the other. But the third minister was careful, "But what if we win . . ." (Heard on Aku's program)

Oncology Dialogue

An 88 year old Japanese man was treated with radiation for asymptomatic metastatic lesions of the lung and extrapleural areas when a Lt supraclavicular node biopsy in 1970 showed metastatic CA. A recent repeat IVP showed a Lt kidney mass . . . Patient was explored and had a left nephrectomy and splenectomy done . . . The diagnosis returned was transitional cell CA. The patient was doing well. Radiotherapist **Ed Quinlan** commented, sotto voce, "Radiotherapists are eternal fall guys. We radiated him, I don't know why . . . Because someone felt we should . . ." Stemmy was his usual vocal self: "This is a classic example of how remarkably well these patients do when left alone . . ."

A 54-year-old Japanese man had painless hematuria and urinary retention for 1 week. IVPs and echograms showed a large mass of the left upper pole. A left nephrectomy and adrenalectomy was done and the path report was renal cell CA. **Grant Stemmerman** elucidated, "The average age for renal cell CA is 55 and the male: female ratio is 2:1. In Hawaii, the incidence in Japanese is 1/2 that of caucasians . . . It usually metastasizes via venous channels and is frequently associated with polycythemia." Radiotherapist **Ed Quinlan** added, "We formerly gave routine postop radiation, but we now concentrate on high risk cases only. Radiotherapy with 5 to 6,000 rads does not add much and high doses to the abdomen cause morbidity of the GI tract . . ." Stemmy asked attending surgeon **Bob Oishi**, "Are you contemplating postop radiation?" Bob was explicit: "Not that I know of . . ." Stemmy: "This is the commonest tumor that undergoes spontaneous regression . . . as you know . . . No one knows why . . . Ben, can you think of an immunological reason?" Immunologist **Ben Gordon** countered with the question, "Is the incidence greater than with malignant melanoma?" **Quint Uy**, like all true chemotherapists, was optimistic: "He may be one of those who goes 10 years . . ."

Visiting Physicians

In September, **Waldemar Johanson Jr.**, associate professor of medicine and head of the University of Texas Health Science Center Pulmonary Diseases Division was here lecturing on pulmonary function tests, diffuse alveolar injury, etc. under the auspices of the Hawaii Thoracic Society's visiting professor program . . .

LeClair Bissell, chief of the Smithers Alcoholism Treatment Center at New York's Roosevelt Hospital and a "recovered alcoholic" herself, spoke on physician alcoholism at the Ala Moana Hotel. LeClair says when an alcoholic doctor seeks help from another physician, the latter often tends to diagnose it as anything but a drinking problem. "I wonder if we physicians have a need to deny alcoholism when we are looking across the desk into a mirror." In her sample of 100 reformed alcoholic physicians, the greatest number were GP's, internists, and psychiatrists, in that order . . . She advises treating alcoholic physicians through a therapist, as is done traditionally, but also having the therapist responsible to another physician who would act as a "patient's advocate" to insure the doctor is casting off his addiction . . .

The Hawaii Heart Association and the HMA conducted a one-day Hypertension Workshop on Sunday, September 21 at the Princess Kaiulani with guest speakers, **Edward Biglieri**,

UCSF professor, and **Ronald Okun**, UCLA assistant professor of Pharmacology and chief of MT Sinai Hospital's Dept. of Clinical Pharmacology. Local physician participants included **David Fergusson**, **Danelo Canete**, **Samuel Gresham**, **Namiko Kominai**, **Ernest Lee**, and **James Orgison** . . . (We managed to attend the workshop and rated it as excellent . . . We were, however, disappointed by the physician turnout . . .)

Conference Notes

Samuel Bessman, Chairman of Pharmacology at USC, was back at KCH in early September. Swarthy, obese, jowled, with hair cut long, aloha shirted and equipped with horn-rimmed glasses and a booming thick voice, Sam gesticulates wildly as he lectures. We found his quips more fascinating than his lecture on PKU:

re microphone: I'm very handicapped with this thing . . . I feel self-conscious . . .

re monkey experiments on PKU and antisocial behavior: One can prove anything since monkeys are expensive and no one can afford to repeat the experiment . . . The group fed phenylalanine milk was grabbed with a head lock or tube-fed while the other group drank regular milk willingly . . .

re Mongoloids and PKU children: When I was a child in med school, Mongoloids were idiots, not morons (ie, poor machinery, but overprogrammed.) We're doing the same thing with PKU children . . . Every paper says the diet doesn't work without an attentive mother, doctor, chemist, etc. . . These children are overprogrammed . . . IQ is product of input and computer divided by time . . .

re medical centers: "You know what a center is? A place where everything is spinning around . . ." "I got this from the John . . ." "You know where the John is?" "At Hopkins . . ." [it's Johns, not John-Ed]

re his own statistics: "Those numbers are kosher . . . Because we do them . . ." "My father used to tell me . . . Remember when you shoot at the King, be sure to kill with the first shot . . ."

re equality: PKU children are born normal . . . Why? . . . The constitution of the United States assures us . . . that all men are created equal . . . Take even an anencephalic monster . . . He registers normal the first day . . . but his IQ keeps going down because he cannot be programmed . . .

Sidney Carter was back at KCH for 2 weeks in late September. Although slightly older, he was still the same youngish, dynamic speaker with lined receding forehead, cropped curly hair and prominent ears whereon gold-rimmed glasses rested easily . . . We gained the following wisdom from his methodical presentation on brain tumors in children: "Brain tumors in children have the same frequency as in adults except there are none before age 1. Brain tumors are surpassed only by leukemia as a form of malignancy in children . . . 70 to 80% are gliomatous in children and posterior fossa tumors are the commonest. Most brain tumors in children are supratentorial and midline . . . The two major sets of symptoms are secondary to increased intracranial pressure and to focal neurological deficits . . . CAT scans (computerized transaxial thermographic scans) are unbelievable . . . They can differentiate grey and white matter, blood, tumor, etc. . . ."

Lady's Corner

(Jokes heard at a recent Lady Banker's Convention)

A boy takes his little brother to the drug store and asks the druggist for a box of Tampax . . . "What size, son?" "Well, I don't know." "Is it for your mother or your sister?" "No, it's for my kid brother." "Why?" "Well, with Tampax you can do anything, including swimming and dancing, and he can't do any of those things . . ."

A wino attends a gospel mission. The preacher says, "All of

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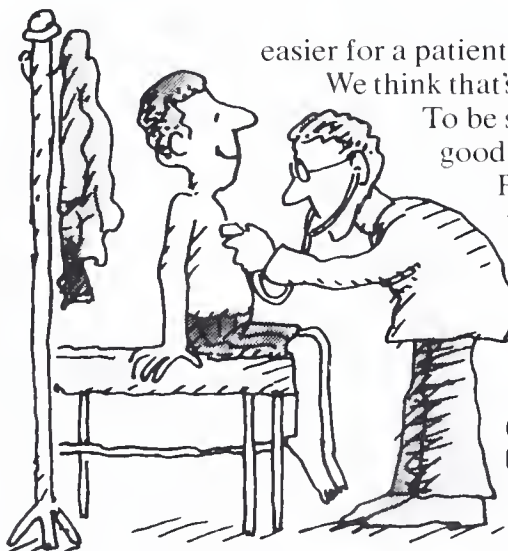
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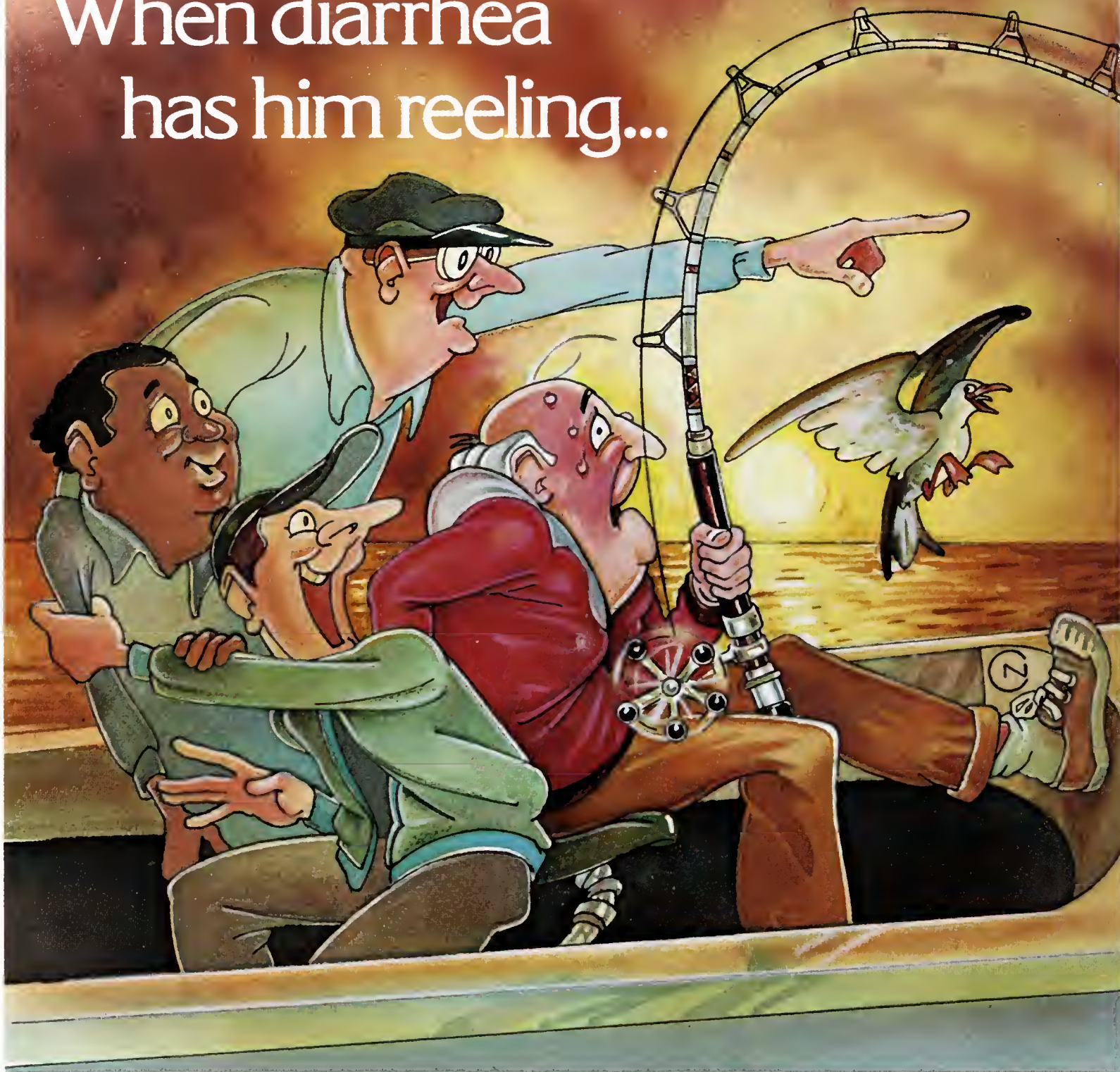
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Each tablet and each 5 ml of liquid contain diphenoxylate hydrochloride 2.5 mg (Warning: May be habit forming), atropine sulfate 0.025 mg

IMPORTANT INFORMATION: This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or Narcan® (naloxone HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with special caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis. In severe dehydration or electrolyte imbalance, withhold Lomotil until corrective therapy has been initiated.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage. Use with care in patients with acute ulcerative colitis and discontinue use if abdominal distention or other symptoms develop.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing, hyperthermia, tachycardia and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria, paralytic ileus, and toxic megacolon.

Dosage and administration: Lomotil is contraindicated in children less than 2 years old. Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist may be used in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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you who want to get to Heaven, raise your hands . . ." They all raised their hands . . . "Now clap your hands . . ." So they all clapped their hands . . . "Now all of you who want to get to Heaven, stand up." They all stood up, except the wino . . . "You there! Don't you want to get to Heaven?" "Sure, but you got a busload already . . ."

The preacher was giving a sermon on the evils of alcohol. He placed a glass of water and a glass of bourbon on the pulpit. Then he pulled out a wriggling nightcrawler from his pocket and dropped it into the glass of water. The crawler wriggled happily. Then he scooped up the crawler from the water and dropped it into the glass of bourbon. It quickly stopped squirming and died. "Aha!" exclaimed the preacher. "Now you can see what happens to those who drink." An alcoholic in the back row commented loudly, "Yes, if you drink bourbon, you won't get worms . . ."

Hors De Combat

Former U.S. surgeon general Luther L. Terry, whose 1964 report on smoking and cancers of the lip, larynx, and lung and other pulmonary disorders says 65% of physicians smoked in 1963 as compared to 15% today. Star Bulletin reporter Tomi Knaefler reports on her local findings: **Fred Gilbert** quit not because of peer and patient pressure, but because whenever he went back to a mainland meeting, some close colleague had died of lung cancer. Fred says, "That gets to you after a while . . . I just stopped when I became aware of the situation. I got no major benefit from smoking anyway . . . Smoking to a large degree is a reflex action—cigarettes with coffee while talking with people or relaxing."

C.M. Burgess quit his 1½ pack habit in 1951 to gain weight because he was getting cold in the water when diving . . . He did and it helped.

Harold Sexton quit his 2 to 3 pack a day 10 years ago because he got tired of coughing. He first switched to smoking small thin cigars twice daily for a few year, then gave that up. Harold has resumed his long distance swimming and is rated in the master's swimming competition . . . "I feel fantastic. I wouldn't smoke again for anything."

James Marnie got tired of hacking one day years ago and threw out his cigarettes. "My mouth always tasted like the inside of a bird cage and at cocktail parties I'd go through a pack and the next day, it was even worse than a booze hangover . . . But since I quit, dammit, I've gained 25 pounds. Everything tastes so good. I'm hungry all the time . . . I've got cottage cheese coming out of my ears . . ."

John Payton, who had smoked since age 20, was stuck with 3 packs a day . . . "Everyone thought I'd never stop because I'm a very compulsive guy . . . But I did three years ago. I saw a friend die of lung cancer and decided to do something." "Quitting was so hard I even thought of taking off for Lanai and staying at the beach for six month by myself. I snapped at everyone. My family asked me to go back to smoking. My poor patients, I snapped at them, too, but they were very devoted and stuck with me. I also dieted and jogged. I took out my hostilities jogging . . ."

Ronald Pion stopped 15 months ago after smoking for 26 years. "On my wife's birthday, we were out to dinner and she said for the first time that she wished I would stop smoking. That really got to me. It was nice. She was expressing her care and concern for me . . ." Ron looked into nonsmoking behavior and it worked . . . He is writing a book on this theory of changing by learning, rather than unlearning.

Harry Arnold quit cold in 1963 when Arnold Wight was found with an inoperable bronchogenic CA. Since 1971 he has smoked 1 or 2 cigarettes after dinner if he's with smokers.

As Advertiser writer Pat Hunter describes it, "Cocaine has been called the 'aristocrat' of drugs, but this 'lady' might turn out to be a femme fatale for some. And yet its use—or misuse—seems to be increasing in Honolulu just as it has done in other US cities, particularly among middle and upper economic level educated 'swingers.' In a related article, Bill

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Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications for use as follows:

Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus. **"Probably" effective:** For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding. **Warnings:** Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism).

If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.

Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens

should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.

Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:

nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
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Mann wrote: "A young physician, 'Lenny,' swears by coke. He is a urologist with a good practice in Honolulu and he describes the drug's effects. 'You can put it up your nose, and it gives your head a tight feeling. Then there's the 'freeze' you get with any good coke. It freezes your gums. When you snort it, you get 'coke drip.' The coke you've snorted drips down and deadens your throat. I could never say this publicly. I strongly recommend coke for sore throats and for losing weight. It's perfect for losing weight—it's like a mild amphetamine and unlike grass, coke kills your appetite. I honestly don't know why it's illegal.'"

When our insurance agent recommended raising our malpractice coverage to a \$1 million from the 100/300 thousand coverage, we looked at the premiums and gasped. But, when we see how in Hilo competent radiologist **George Bracher** was involved in a \$1 million malpractice suit from an IVP death in 1973 and also in Hilo how **Pete Okumoto**, **Bob Morikawa** and **Richard Lundborg** were involved in a \$1.35 million suit for a boy who died after a T&A in 1973, we prudently called our agent and submitted to the added coverage. We also note that on Kauai, **Katok Chung**, **Gonzalo Geroso** and **Patrick Aiu** are being sued for ½ million dollars for the death of a child from skull fracture and other injuries 3 weeks after delivery . . . The three physicians who assisted in the birth of the child have issued a general denial to the charges . . . Then there is the case of a Honolulu psychiatrist, **K Y Lum**, who was a defendant in a \$2.6 million lawsuit by the family of a murder victim of a State Hospital dischargee, till the family discovered that K Y had been appointed to examine the suspect after the crime . . . With the public so suit conscious, it makes us shudder.

T. Lawrence Jones, president of the American Insurance Association says that although the headlines on the malpractice insurance crisis has faded from the headlines in recent months, the situation is as bad as ever and there are still no answers. He lays much of the blame for the problem on the medical and legal professions. "The former generates too many incidents which result in claims for damages. The latter operates a system which is too inefficient and too costly." He suggests as a promising solution the channeling of some malpractice liability from doctors to hospitals, where 75% of malpractice claims arise. By putting more responsibility on hospitals and physician specialists who work in them, general practitioners who work mostly away from hospitals would be relieved of top malpractice rates. He also suggests that malpractice cases be reviewed by panels of experts rather than by lay men who now compose the juries. Also that patients feel more inclined to sue these days because they have less sympathy toward their doctors as dills go up and house calls go down . . .

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"The patient is a static abnormality—who is not going to either get worse or improve." (Newspaper quote of neurologist **Jordon Popper** testifying in the Michael Figueroa case)

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Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage. Use with care in patients with acute ulcerative colitis and discontinue use if abdominal distention or other symptoms develop.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing, hyperthermia, tachycardia and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria, paralytic ileus, and toxic megacolon.

Dosage and administration: Lomotil is contraindicated in children less than 2 years old. Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist may be used in severe respiratory depression. Observation should extend over at least 48 hours.

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Should a specially prepared package insert be made available to patients?

Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration



Dr. James H. Sammons
Executive Vice President
of the American
Medical Association



The idea of a so-called patient package insert has been around for a long time. Many physicians already use written instruction sheets to provide patients with information about the drugs they are taking. And some physicians give verbal instructions; but in too many instances these are what I call eye-glazing exercises. I have seen patients sit with glazed eyes listening to a rapid-fire lecture by a hurried physician who has 20 people out in his waiting room. These patients aren't given sufficient understanding and therefore do not follow instructions. So I think the idea of an official package insert for patients is a good one. Perhaps we should really think of this kind of information simply as an extension of drug labeling.

The benefits of patient involvement

Many physicians may not realize how frequently a patient obtains his drug information from Aunt Tillie or the next door neighbor. And this information is almost always bad or irrelevant to the case at hand. Furthermore, the incentive to go along with a prescribed program is slim if the only reading matter the patient receives, along with his prescription, is a bill.

As an educator I am impressed by the principle that the best way to get someone to do something is to involve him in the process. So the

I think there are advantages as well as some real disadvantages in a patient package insert. When you begin to use semi-medical or medical terms to describe complications or possible sequelae of disease or treatment, you may frighten the patient—particularly since the more highly sophisticated patient is not the one who is going to read the insert. The patient who will read it is the one most susceptible to fright and confusion by the language.

On the positive side, a package insert will probably give the patient better insight into why he is being treated the way he is, and it may give the physician a little bit more time. But it does not remove from the physician the need or obligation to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should be warned of the possibility of serious side reactions—to know what the real dangers are. But it doesn't do a bit of good to indicate that a patient on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that fright engendered by the insert may possibly outweigh the potential good.

main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is

no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a pa-

tient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

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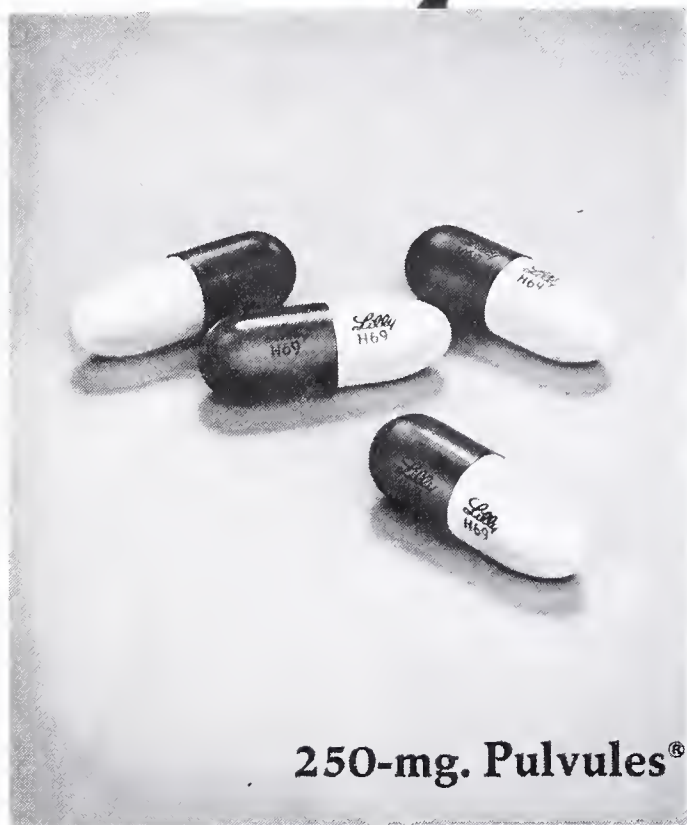
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Pulmonary Embolism In Hawaii: An Ethnic Study

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Pulmonary embolism (PE) is a major cause of death in the United States, with an estimated 142,000 deaths per year.¹ This death rate is nine times that of leukemia and four times that of breast cancer.² However, various authors report that PE is relatively infrequent in Japan.^{3, 4, 5} Hirst, Gore et al have reported an autopsy incidence of 1.5% to 2.0% in Japan.³ This contrasts with an autopsy incidence of 18.5% or greater in the U.S.^{3, 6}

Previous studies have shown that the Japanese in Hawaii have different disease patterns than native Japanese.⁷ Some of the diseases that show a rising incidence among the Japanese in Hawaii are myocardial infarction, diverticulosis of the colon, and colon carcinoma. These same three diseases, along with pulmonary embolism and deep vein thrombosis, have been described by Burkitt as diseases characteristic of modern Western civilizations.⁸ They are rare in undeveloped areas of Africa and India, but are among the commonest diseases in the U.S. and Great Britain. Burkitt concludes that epidemiological evidence implicates primarily environmental factors, specifically Western dietary customs, in the relative occurrence of these diseases.⁹

Stemmermann has reported that pulmonary embolism is a rare autopsy finding among the Japanese in Hawaii.⁷ Yet based on the above information, it might be expected that pulmonary embolism would occur more frequently among the Japanese-Americans than in native Japanese.

To further explore this question we have correlated ethnic background with the diagnosis of pulmonary embolism in 101 consecutive patients referred for ventilation-perfusion (V/Q) lung scintigraphy.

Methods

V/Q LUNG SCANS

All perfusion lung scans are performed on the scintillation camera following intravenous injection of Tc-99m-macroaggregated albumin. Four to six views are obtained on each patient. When the perfusion scan is completely normal, the study is terminated and interpreted as negative for pulmonary emboli.

When perfusion defects are detected, the patient returns within 24 hours for evaluation of regional ventilatory distribution. Ventilation scans are performed on the scintillation camera following inhalation of aerosolized Tc-99m-phytate. Care is taken to match the position of the views precisely with the perfusion images. Both are delivered in the upright position at tidal volume respiration. Typical V/Q patterns are shown in Figure 1.

DIAGNOSTIC CRITERIA

A normal perfusion scan, when properly performed, is known to exclude pulmonary embolism with high reliability.¹⁰ Therefore all patients with normal perfusion scans were included in the study, and interpreted as negative for pulmonary emboli.

All abnormal perfusion scans were followed within 24 hours with ventilation studies. A segmental or lobar perfusion defect, accompanied by maintenance of regional ventilation, was interpreted as positive for pulmonary emboli. Patients with matching V/Q abnormalities were interpreted as negative for PE. The one exception was a hemodialysis patient who had typical clinical and radiographic signs of infarction. The diagnosis of infarction in this patient was confirmed at autopsy. In all other cases, however, patients with only abnormal perfusion scans were excluded from the study *unless* a ventilation study was available to assist with interpretation.

For each patient the V/Q findings were cor-

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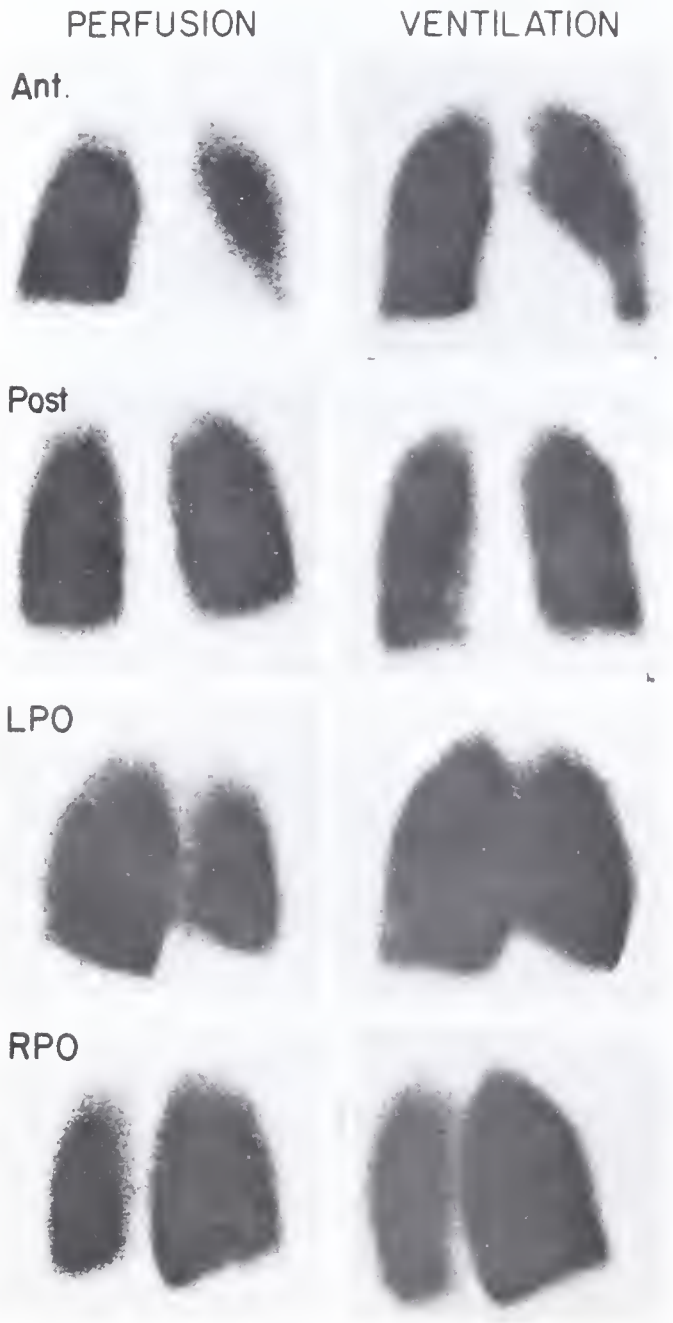
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related with history, physical findings, chest x-ray, and available laboratory data, especially arterial blood gases. Clinical course and repeat V/Q studies provided confirmation of the diagnosis in most cases. However, for the purposes of this study, any patient whose V/Q findings were equivocal, or whose clinical diagnosis was considered uncertain, was considered negative for PE.

Results

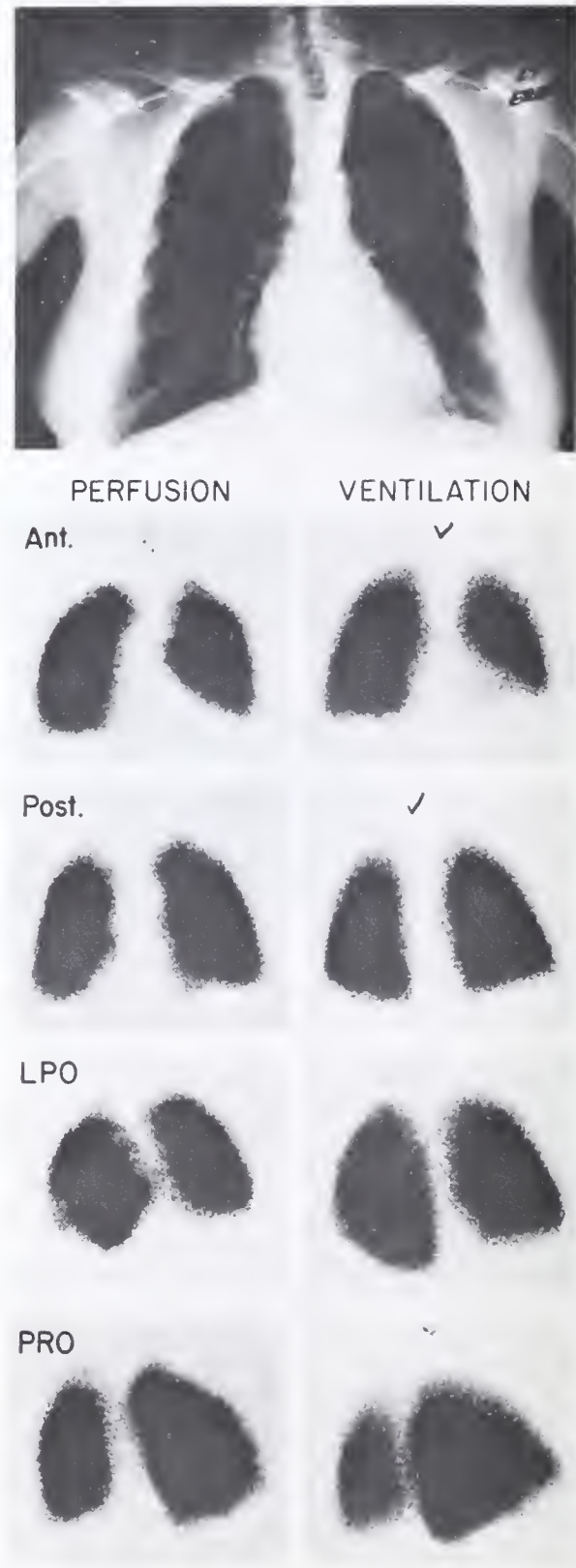
There were 101 V/Q studies which were acceptable by the above criteria. PE was diagnosed in 28, or 27.7%, of these patients. Table 1 shows the correlation with ethnic background. Of the 54 Japanese patients studied, 25.9% were diagnosed as pulmonary embolism. The diagnosis of PE was made in 20.0% of the Caucasian patients, and in 34.4% of remaining patients of various ethnic backgrounds.

FIG. 1A)—Normal V/Q study. The distributions of perfusion and ventilation are perfectly matched.



There is no significant racial difference in the occurrence of PE among the groups in the study population ($p < 0.05$). The patients of Japanese ancestry were as likely to have PE as the other ethnic groups.

FIG. 1B)—Typical findings in pulmonary embolism. The segmental perfusion defects are best visualized on the oblique views, and ventilation is maintained to these segments. The advantage of imaging both ventilation and perfusion in the oblique position is apparent.



Discussion

Most published reports on the incidence of pulmonary embolism are based upon autopsy data. For a disease which is overwhelmingly nonfatal, autopsy data has some obvious limita-

FIG. 1C)—Typical findings in a patient with chronic obstructive airway disease. Each of the perfusion defects can be explained by a corresponding ventilation defect. The oblique views permit exact correlation of V/Q distributions.

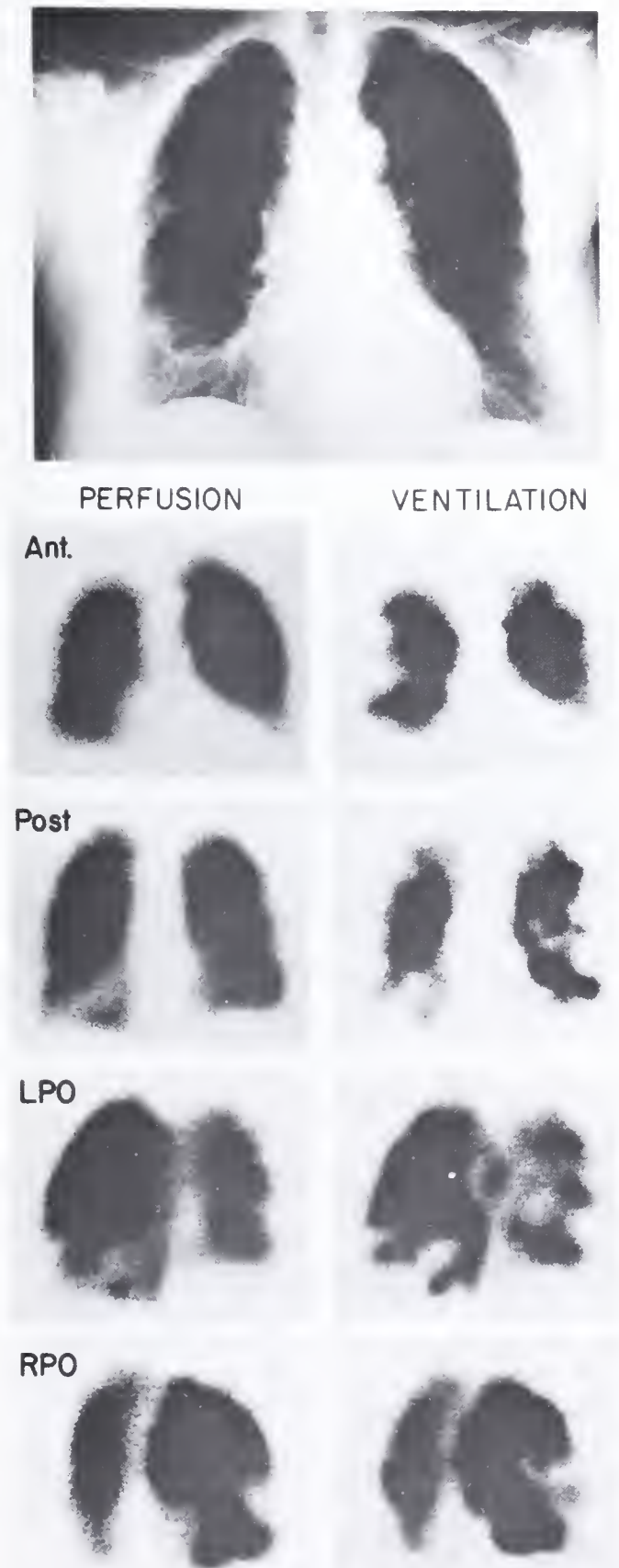


TABLE 1.—Incidence of Pulmonary Embolism by Ethnic Origin:

ETHNIC BACKGROUND	TOTAL V/Q STUDIES	POSITIVE FOR PE	
		Number	Percent
Japanese	51	11	25.9%
Caucasian	15	3	20.0%
Other	32	11	34.1%
TOTAL	101	28	27.7%

tions. In addition, the autopsy detection of PE varies greatly with autopsy technique.¹² Morrell and Dunnill conducted an autopsy study in which the right lungs were subjected to routine examination, whereas the left lungs were meticulously examined.¹³ They found indications of PE in 11% of the routinely examined right lungs, but in 52% of the left lungs.

The clinical diagnosis of PE is also notoriously difficult and inaccurate.^{10, 14} Because of its vague, nonspecific signs and symptoms, it has been found that ante-mortem diagnosis is made in fewer than 50% of cases.¹⁵

It is therefore apparent that true incidence figures for pulmonary embolism are not available. However, ethnic data on deep vein thrombosis, the common precursor of PE, are available. The advent of I-125 fibrinogen leg scanning has made it possible to detect deep vein thrombosis easily and reliably in the clinical setting. The average incidence in Caucasians in British hospitals following elective surgery is 30% or greater.^{16, 17, 18, 19} This contrasts with a 12% incidence in Sudanese patients, 11% in Bantu and Indian patients in South Africa, and 12% in Queensland, Australia.^{20, 21, 22} These figures seem to follow the same general pattern as the autopsy PE data. Both PE and DVT do appear to be much more frequent in Western, developed countries.^{8, 23}

Recognizing the difficulties in determining the clinical incidence of PE, we have attempted in this study to compare relative incidences of PE among patients within the same hospital. Since most patients suspected of PE are referred for V/Q lung imaging, this appears to be the best available study group in the clinical setting.

Despite the limitations of this type of data, the results do indicate that there is no significant difference in the clinical incidence of PE between our Japanese and Caucasian patients. Although this finding is consistent with the known changing disease patterns among the Japanese in Hawaii, it appears to contradict previous autopsy studies. There are at least several possible explanations for this discrepancy:

- (1) The clinical diagnosis of PE is being made more frequently in recent years, but this may reflect the availability of improved, non-invasive diagnostic methods, rather than a true increase in incidence. At least one study suggests that this is the case.²⁴

- (2) Accurate autopsy detection of PE requires careful, meticulous searching. Possibly PE have been overlooked at routine autopsy. Although this could explain some of the differences between autopsy studies, it is not likely to be the major factor.
- (3) Another potential explanation would be that PE in the Japanese-Americans runs a more benign course, and is less frequently fatal. Although this would explain the lower autopsy incidence, it would be particularly difficult to prove.
- (4) Finally, these findings may indicate a true increase in PE incidence among the Japanese in Hawaii. Both PE and DVT, according to Burkitt, are strongly associated with myocardial infarction, carcinoma of the colon,

and diverticulosis. These latter three diseases are known to be more frequent in Japanese-Americans than in native Japanese, and therefore it might be expected that this would also be the case for PE.

The current study cannot determine which of the above factors is predominant. It is possible that each of these factors, in various degrees, is contributing to the discrepancy between autopsy and clinical PE data.

However, from a practical clinical standpoint, it can be concluded that PE occurs with a clinically significant frequency in our patients of Japanese ancestry. Since the diagnosis of PE ultimately depends upon clinical suspicion, no patient, regardless of ethnic background, should be considered free of risk.

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Pernicious Anemia In Hawaii-Japanese

F.H. FUKUNAGA, M.D. and M.M. KANESHIRO, M.D. *Honolulu*

Pernicious anemia is a systemic disease of vitamin B-12 deficiency, usually seen in middle or late adult life. It is a chronic illness characterized by the lack of intrinsic factor in gastric secretions. Pernicious anemia is usually considered rare in Japanese, reported in less than 0.05 per 100,000 Japanese as compared to the European rate of 130 per 100,000.^{1,2}

Seven cases of pernicious anemia were discovered in Hawaii Japanese during a three-year period at the Kuakini Hospital, 5 of them in the last nine months. Kuakini Hospital is a 208-bed general medical-surgical institution where approximately 5,300 patients admitted each year are of Japanese ancestry. The approximate number of Hawaii Japanese is 215,000 according to a recent (1972-74) population survey by the State Department of Health.

Case Report

Case 1: H.S., a 78-year-old Japanese man, complained of anorexia, weight loss, and cramps in both legs, without paresthesias or hypoesthesia. Significant physical findings included icteric sclerae and a smooth tongue. The laboratory findings are listed in Table I. The intrinsic factor antibody test was negative. Gastroscopy revealed a thin, atrophic mucosa; biopsies showed severe atrophy and intestinalization of the body mucosa. Bone marrow examination revealed a megaloblastic maturation pattern. A therapeutic trial of 1 μ g vitamin B-12 parenterally per day was followed by a prompt rise of the reticulocyte

count from 1% to 9.9% on the fourth and 18.4% on the fifth day. The hemoglobin rose to 7.9 gm and hematocrit to 25.2% by the fifth day.

Case 2: M.I., a 57-year-old Japanese man, complained of easy fatigability, weakness, anorexia, and nausea. Physical examination revealed a pink and slightly smooth tongue. The blood findings are listed in Table 1. The Schilling's test was compatible with pernicious anemia. The bone marrow revealed a megaloblastic maturation. The "flushing" dose of vitamin B-12 given in the Schilling test was followed by a reticulocytosis from 1.1 to 30.7% by the fourth day.

Case 3: F.K., a 76-year-old Japanese woman, was admitted with chills and fever due to pneumonia. Physical examination revealed a smooth red tongue and a wide-based gait. She also complained of tingling of her hands and feet, and there was decreased vibratory sensation in all extremities. The laboratory findings are listed in Table I. Gastric analysis revealed no free acid. Gastric biopsies showed severe atrophy and confluent intestinalization of the body mucosa. Treatment with parenteral cyanocobalamine, 1 μ g daily, was followed by a reticulocytosis from 0.9 to 4.2% by the seventh day.

Case 4: A.O., a 62-year-old Japanese woman, complained of weakness of both legs and numbness and tingling of both hands. She required a cane and her husband's assistance to walk. Physical findings included decreased vibratory

TABLE 1.—Laboratory Findings

	CASE 1	CASE 2	CASE 3	CASE 4	CASE 5	CASE 6	CASE 7
AGE & SEX	78 M	57 M	76 F	62 F	72 F	72 F	61 M
WBC	3,000	4,500	7,000	6,200	4,800	4,100	7,600
RBC (million)	1.16	1.51	2.63	3.30	1.52	2.59	1.93
Hgb (gm dl)	4.9	6.1	10.1	12.9	6.7	10.6	8.1
Hematocrit (%)	15.0	19.1	30.9	37.5	20.8	31.8	25.9
MCV (μ^3)	125	125	117	111	135	123	131
MCH ($\mu\mu\text{g}$)	44.3	42.5	39.9	38.3	45.2	41.4	43.0
MCHC (%)	33.2	32.6	32.9	34.6	33	33.3	32.3
Platelets	99,000	66,000	138,000	295,000	114,000	ND	148,000
Serum B-12* (N = 300-900pg/ml)	50	127	150	155	175	135	141
Serum folate* (N = 5-21ng/ml)	24	25	19	25	25	25	20
Gastrin* (N = 50-155ng/ml)	ND	325	763	481	ND	988	ND
Bilirubin	1.1	2.4	1.0	ND	0.4	ND	2.7
LDH (N = 30-120 units)	269	1820	ND	ND	223	ND	ND
Serum iron	205	ND	78	102	ND	ND	ND
TIBC	205	ND	202	248	ND	ND	ND

ND = Not Done

*Determined by radioimmunoassay

sense of both legs, hyperactive deep tendon reflexes, a positive Babinski and Hoffman's sign, and a Romberg to the right. Her tongue was smooth and beefy red, and she had complained for about five years that shoyu and acid fruits irritated her tongue. The peripheral blood findings are listed in Table 1. Gastric analysis revealed an absence of free acid. The gastric biopsy revealed advanced atrophy of the body mucosa with confluent intestinalization. Both the upper GI and barium enema x-rays were negative. The Schilling test was compatible with pernicious anemia. The bone marrow aspirate revealed a few megaloblasts and relatively normal cellularity. The test for anti-intrinsic factor antibody was positive. Treatment with vitamin B-12 was followed by a marked improvement of her neurologic symptoms and she is now able to walk without a cane or any other assistance.

Case 5: M.Y., a 72-year-old Japanese woman, complained of lower-extremity weakness and tiredness. She had been seen in 1966 and 1967 with similar complaints, and treated with blood transfusions without evaluation of her anemia. The peripheral blood findings are listed in Table 1. Physical examination revealed icteric sclerae and a pink, smooth tongue. Gastric analysis revealed absence of free acid and the upper GI and barium enema x-ray studies were negative. Bone marrow examination revealed megaloblastosis and a Schilling test was compatible with pernicious anemia. Treatment with liver extract was followed by reticulocytosis of 10.2% by the fourth day.

Case 6: K.C., a 72-year-old Japanese woman, complained of weakness and tiredness. Physical examination revealed hypoesthesias of both hands but her tongue appeared normal. The laboratory findings are listed in Table 1. The bone marrow showed a megaloblastic maturation. The Schilling test was compatible with pernicious anemia. Treatment with vitamin B-12 was followed by a prompt improvement of her symptoms.

Case 7: K.I., a 61-year-old Japanese man, complained of dyspnea on exertion, and tiredness. He was treated in 1972 with blood transfusions for anemia. Physical examination revealed a smooth tongue and slightly diminished vibratory sense. The laboratory findings are listed in Table 1. The peripheral blood smear showed megaloblastic red blood cells. The Schilling test was compatible with pernicious anemia. Treatment with B-12 showed a reticulocytosis of 10% by the seventh day.

Discussion

Pernicious anemia is often overlooked in Japanese, but also frequently not recognized in European descendants living in the United States.³ It has always been considered rare in Japanese and other Asians.^{1,2} The seven cases described in this report strongly suggest that the prevalence of pernicious anemia in Japanese may be higher than previously believed.

Pernicious anemia is a systemic deficiency of vitamin B-12 and involves the cells of the blood, gastrointestinal tract, and the peripheral and

TABLE 2.—Significant Symptoms and Physical Findings

	CASE 1	CASE 2	CASE 3	CASE 4	CASE 5	CASE 6	CASE 7
Weakness	No	Yes	No	Yes	Yes	Yes	Yes
Anorexia	Yes	Yes	No	No	No	No	Yes
Smooth tongue	Yes	Yes	Yes	Yes	Yes	No	Yes
Paresthesias or hypoesthesia	No	No	Yes	Yes	No	Yes	Yes

central nervous systems. The major expression of the disease may mimic some other disease or aggravate another illness such as coronary insufficiency. Much of the difficulty in the diagnosis of pernicious anemia is due to the lack of any single typical presentation, and its frequent resemblance to several other diseases.

The pathogenesis of the B-12 deficiency is a lack of intrinsic factor. Deficiency of B-12 could also be secondary to gastrectomy or gastritis. An eighth case of vitamin B-12 deficiency in our series was the result of a gastric resection with a Billroth II anastomosis 15 years prior to the onset of anemia in a 57-year-old man. He was seen a year prior to the anemia for treatment of a myocardial infarction and was noted to have macrocytosis (MCV 116 cubic microns and hemoglobin 14.5 gm/dl), but no diagnostic studies were done. He was readmitted a year later complaining of exertional dyspnea and his laboratory studies revealed a hemoglobin of 8.7 gm/dl, hematocrit 25%, RBC 1.91 million, MCV 130 cubic microns, MCH 46.3 and MCHC 35%. The serum vitamin B-12 was 26 pg/ml, folic acid 16 ng/ml, serum iron 256 and the TIBC 274 μ g/dl. Schilling test revealed 1.25% urinary excretion at 48 hours, with improvement to 31% after giving intrinsic factor. He had a reticulocytosis of 14.5% two days following the flushing dose of vitamin B-12 used in the Schilling test. Other causes of vitamin B-12 deficiency include dietary defect, which is very rare in the United States, and intestinal defects such as sprue and blind loops that cause malabsorption.^{4,5}

Determination of serum vitamin B-12 will separate normal individuals from those with deficiencies. The Schilling test will indicate the absorption defect and the use of intrinsic factor will differentiate pernicious anemia from small bowel absorption defects. Serum folate has been reported to be elevated in about a third of the cases of pernicious anemia⁵ and it was increased in five of our cases. The complication of deficiency secondary to gastric resection is usually seen about 15 years after the operation and is more likely after removal of over 60% of the stomach. Gastric biopsies in 3 patients in this series all showed severe atrophy with intestinalization. Serum LDH activity was elevated in the 3 patients tested.

Weakness and ease of fatigability were the most common presenting symptoms. Other common symptoms and signs noted are shown in Table 2.

The most common early laboratory finding in our series was macrocytosis of more than 111 cubic microns. The macrocytosis may precede the anemia and symptoms by as much as one year. This was noted in our Case 4 where the patient presented with neurologic symptoms and macrocytosis without anemia.

The one patient with B-12 deficiency secondary to gastric resection also showed macrocytosis without anemia a year before he was noted to be anemic. Perhaps the greatest contributing factor in the increased awareness and diagnosis of pernicious anemia is the automated blood counter which measures or calculates seven blood parameters including the MCV. The increased MCV was the most common finding that led to further investigation in our series.

The higher prevalence of pernicious anemia in Hawaii Japanese may be analyzed from several standpoints; the most obvious is whether or not the diagnoses were correct. All seven patients had red blood cell macrocytosis and low serum B-12 levels. Cases 2, 4, 5, 6, and 7 had Schilling tests compatible with pernicious anemia. Although Cases 1 and 3 did not have Schilling tests, both underwent gastric biopsies which revealed atrophy characteristically related to a lack of intrinsic factor. The diagnosis of pernicious anemia on the basis of intrinsic factor deficiency was confirmed in five and strongly suggested by gastric biopsy in the other two cases. The difference in the reported prevalence of pernicious anemia in the Hawaii and native Japanese probably is partly due to underdiagnosis in Japan, but may also reflect a difference in life style between Hawaii and Japan. This difference has been shown to be significant in other diseases such as cancer of the colon¹.

Summary

Pernicious anemia in the Japanese is not the rare disease we once thought it was. Increased awareness of the disease, and macrocytosis, should prompt one to do further confirmatory tests.

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H. TOM THORSON

The AMA 29th Clinical Session has come and gone. From all reports it was an excellent meeting. The Sheraton Waikiki should be congratulated on the high quality of the hotel service as the AMA staff claims the Aloha Spirit really was visible and that they never had had such cooperation.

Big questions before the House of Delegates had to do with the reorganization of the AMA. Reference Committee F considered the committee reports and resolutions in connection with the multiple approaches. A full analysis of the actions will be found in the AM News and the JAMA.

Seminars and meeting were held on the neighbor islands following the adjournment of the House of Delegates. Others holding such meeting were the Foundations for Medical Care, National Blue Shield, AAMSE, AMA Staff, ASIM, and the Family Practice group.

The ugly head of the malpractice insurance problem was clearly visible and a number of proposals were considered. They ranged all the way from a resolution urging all physicians to drop their insurance to recommending the inclusion of insurance in a national health insurance act.

Basic solutions suggested are in the area of our concern, namely, tort legislation, claims adjudication, court processes, and professional discipline. From all the states that have enacted legislation we have learned a little and hopefully our legislature will respond with corrective measures as suggested by HMA. We had hoped for a draft of the proposed omnibus bill but it is not ready at this writing.

HMA staff testified before the Council on Medical Service relative to the problem of the Pacific PSRO and the Trust Territory.

Poison Information Center is providing

twenty four hour coverage for data on toxicity, ingredients, and treatment for various poisonous substances—call 537-1831. Expansion to the neighbor islands is expected in January. Questionnaires are being sent to physicians for comments. Please Kokua!

Office of Consumer Protection advises that certain products being distributed by Jaimeson-McCames and Pharmacare, Inc., of St. Louis Missouri, are improperly labelled. Any physician using products from this firm should contact the HMA office promptly.

California Medical Association testifies before their legislature that 45% of physicians in California may retire unless relief is obtained in the malpractice insurance mess.

Good News is received once in a while—Industrial Insurance Company, carrier for HMA Group TDI advises that there will be no increase for 1976 premiums. It will remain at 58¢ per \$100 payroll. They cite cost control as the critical factor—keep up the good work! For information concerning coverage call Industrial Insurance Company 521-1477—ask for Don Vaughan.

MAC (Maximum allowable costs) regulations are being made the subject of a suit by the AMA.

Retraction—Last month we reported that HMA was filing a letter of intent to be a Health Systems Agency under 93-641. Upon further review and examination, this decision has been reversed. HMA will not file.

Member Lost in Earthquake—Dr. James A. Mitchell, Hilo surgeon, while conducting a campout for Boy Scouts, was killed in the earthquake on the big Island. A eulogy was given before the House of Delegates of the AMA at their opening session. HMA extends condolences to Dr. Mitchell's family.

HMA hosted the California Delegation at a Chinese Dinner, December 2, 1975 at the Oceania Floating Restaurant. There were approximately 200 at the party.

Surgical Conference in Bombay January 11-16, 1976. Speakers will include Dr. Christian Barnard, South Africa; Dr. Werner Heller, Germany; Dr. Russell Nelson, USA; Dr. Tin Yu Lin, Taiwan; and others. For further information contact Dr. Clement B. N. Chun-Ming, 1697 Ala Moana Blvd., Honolulu 96815.

Internist Wanted—Waimea Clinic, Inc., Waimea, Kauai, Hawaii, needs an internist—would consider a locum tenens arrangement.

Contact Charles C. Custer, M.D., P. O. Box 427, Waimea, Kauai, Hawaii 96796.

Joint Commission on Accreditation of Hospitals announces that there will be no review of hospitals in Hawaii during first quarter of 1976.

Cancer Center seeking Associate and Assistant Professor, Radiation Therapy (15% time). Must be Board Certified in Radiology or Radiation Therapy with experience in educational programs. Contact Ruth James, UH School of Medicine.

Honolulu County Society installs new officers. December 9, 1975 was the annual meeting date with Dr. Douglas B. Bell, II, being installed as President, Dr. Ann Catts, President-Elect, Dr. Pat Walsh as Secretary, and Dr. Walter W. Y. Chang as Treasurer.

Tel Med inaugurated in Hawaii sponsored by the Hawaii Medical Association and Hawaii Medical Service Association with a startup grant from the Chamber of Commerce of Hawaii. Approximately 140 informational tapes are available for public use and the call number is 521-0711. The installation is at the Nurses and Physicians Exchange and interested doctors should stop to see what the setup looks like.



Prognosis For The Family Physician I

Primarily through the efforts of the American Academy of Family Physicians, but with large support from the Congress of the United States, there has been a surge of interest on the part of

medical students to get into Family Practice Residencies. The field has been expanding steadily. The objective, of course, is for the young physician to be able to go into a *locus* of family practice, in which the family physician plays a "unique role in patient management, problem solving, counseling and as a personal physician who coordinates total health care delivery." (AAFP policy). His service is comprehensive, with emphasis on the family unit, and as a physician offering primary care, he stresses not only "first contact care", but also assumes continuing responsibilities both in therapeutics and in health maintenance.

How does the student look at this broad picture? In a sense, the prospect is awesome.

The student's medical school faculty has been made up mostly of specialists, and these people have an inborn error of outlook that is quite prejudicial to the concept of Family Practice. With tongue in cheek (and likely to have it bitten off when given an uppercut!), we might define a specialist as a person so afraid of NOT knowing it all even in a restricted field of medicine and despite narrowing the field of vision to the left little toe only, s/he dare not look at the whole patient. To these people, a generalist is an unmitigated horror, who should never be graduated with an MD, much less given a license to "practice medicine and surgery" by the state. The student, therefore, has had hammered into his brain continuously the theme: "Learn one system well. Specialize, specialize, specialize! You'll never be able to encompass the whole of medical knowledge; therefore, skim over the rest and start narrowing your field of interest".

All this is understandable and quite difficult to controvert. The older generation MD of today looks at the vast quantity of new medical knowledge and is thankful he does not have to do it all over again. He realizes he might not have had the temerity to become a generalist, had he had to face then, the knowledge of today.

So . . . how does one argue the case? How do we preceptors in Family Practice speak in favor of our "specialty"? Must we shamefacedly admit that we generalists know only a little bit about a whole lot of medicine? Or, do we really feel comfortable and proud to say that we do know a whole lot about a great many of the most common and important aspects of the art and science of medicine, that we have at our beck and call the best of consultants from which we choose the one for our patient, that we are more concerned with the whole person that is our patient—not just the part, or organ or disease process—and that this concern is not only for now—the time of crisis in that patient—but forever, through other crises and through health monitoring and maintenance too. Finally, do we assure our patient that our interest in his welfare goes even further: To that of his family, his inter-relationship with other humans, his job, his community, his pocket-

etbook, etc.?

A medical manager? Yes! A triage officer? No. Aren't these one and the same? Definitely not! A triage officer sees the patient once, and never again.

More anon

J.J.F.R.



Hawaii Academy of Family Physicians' Newsletter

J.I. FREDERICK REPPUN, M.D.

NEW MEMBERS—W. Gordon Podolsky, Capt. MC, USNR is a new Associate member whom we welcome. Under the new AAFP classification he will probably be listed as Active in 1976.

APOLOGIA—we must indeed apologize for stating in the October NEWSLETTER that **Guy Heder** was dropped! He reinstated himself by reminding his wife/secretary she was delinquent in paying up his dues. We saw Guy at the AMA Scientific Meeting with his son, a medical doctor in military service; it was hard to say which was father and which was son.

NEWS OF MEMBERS—There were others who attended the AAFP Scientific Session in Chicago in October: **Bob Benson**, **Masato Mitsuda** and **Michael Padwick**. **Felix Lafferty**, **Michael Padwick** and **Mark Wentworth** received their degree of "Fellow" at the cap and gown ceremony. Mark, by the way, will be getting out of the military in July and plans to be associated with the Waimea Medical Group on Kauai. **Col. Bill Brownlee** (retired) is now in Colorado Springs. **Bob Bell** has given up Family Practice and is now with the St. Francis Hospital Emergency Room Physicians. We've heard indirectly that **Pat Lowry** of Waianae went to Guam and returned to become a full-time student in UH School of Public Health and due to get his MPH soon. It was great to see **Cas Jasinski** back on his feet and his voice returning to full volume after his thyroid surgery. His "nodule" was discovered at one of our meetings by wife Doris under the coaching of our guest speaker Win Lee MD.

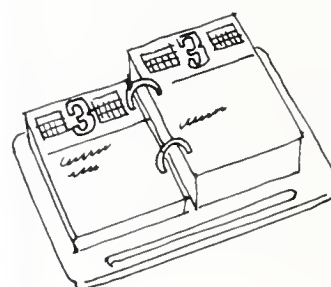
BRASS, BRASS and more BRASS!—The devastating Big Island earthquake and tsunami might have been the result of all the AAFP big-wigs descending upon little old State of Hawaii. Pres. **Herb Holden** addressed the meeting of the American Association of Medical Clinics in Lahaina early in November. The AAFP Board of Directors scheduled one of its regular meetings on Maui right after the close of the AMA 29th Annual Clinical Convention on Oahu.

So many of our leaders attended the AMA session in Waikiki, that the Hawaii Chapter seized the opportunity; gracious host and hostess **Cas** and **Doris Jasinski** opened their home in Manoa on 1 December to 33 of these guests (there were also some 29 of us locals present to welcome the

brass): President and Mrs. **Carl Hall**, Immediate Past President and Mrs. **Herb Holden**, President-elect and Mrs. **Herbert Huffington**, Chm of the Board and Mrs. **Jack Kelly**, Speaker and Mrs. **Les Huffman**, Vice-Speaker and Mrs. **Sam Nixon**, Board member **Woody Lewis**, Chm of the 1976 Boston AAFP Scientific Assembly and Mrs. **Bill Taggart**, 1967-68 (Past) President & Mrs. **George Burket, Jr.**, Committee on Scientific Program members **Ed & Mrs. Flournoy**, **Dick & Mrs. Simmons**, **Sandy & Mrs. Bloom**, **Jose & Mrs. Castel**, **Bill & Mrs. Allen**, Education Commissioner & Mrs. **Tom Stern**, **Dick & Mrs. Inskip** (he is our regional advisor who gets to OK all our requests for Category P credit courses) also on that Commission as is **Bill Allen**; last but not least, our favorite Executive Director & Mrs. **Roger Tusken**.

CORE CONTENT REVIEW—the Hawaii Chapter received a dividend of \$88 rebate for coming in first with 37.3% (22 members) of our membership participating in the 1975-1976 Review, of all the states!

AMA HOUSE OF DELEGATES—numbering over 240, included quite a number of AAFP members. This was the first time this federation of state associations held its meeting in Hawaii.



Continuing Medical Education

CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS:

Ongoing

Kaiser Hospital

(Contact CME Dept. for further information)

Kauaikeolani Children's Hospital

1. Weekly Grand Rounds

2. Weekly Monday Noon Seminars

3. Visiting Professor Program

Kapiolani Maternity Hospital

1. Tuesdays—CME Program, 1:00-2:00

2. Grand Rounds, Wednesdays, 7:30-8:30

3. Visiting Professor Program (see Special Events)

Kuakini Hospital

1. Hematology Rounds, Monday, 1:00-2:00 p.m.

2. Gastroenterology, Tuesday, 8:00-9:00 a.m.

3. Oncology Conference, Thursday, 8:00-9:00 a.m.

4. Endocrine Conference, 2nd Wednesday each month, 1:00-2:00 p.m.

5. Medical Statistics, 3rd Tuesday each month, 1:00-2:00 p.m.

Proceedings of
The House of Delegates



119th Annual Meeting
October 25, 26, 1975

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HAWAII MEDICAL ASSOCIATION—Committees 1974-75

COMMISSIONERS

Medical Education and Peer Review	Ann B. Catts
Internal Affairs	R. Varian Sloan
Legislation	George Goto
Medical Services	Albert C.K. Chun-Hoon
Public Health	Calvin C.J. Sia
Interprofessional & Public Affairs	Rowlin L. Lichter
Health Service and Care	Douglas B. Bell, II

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 Claude V. Caver (1976)
 William W.L. Dang (1977)
 Fred I. Gilbert (1976)
 Lawrence H. Gordon (1976)
 John J. Lowrey (1975)
 Wilbur S. Lummis (1976)
 George H. Mills (1975)
 John F. Morris (1976)
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 Richard Omura (1977)
 Theodore T. Tomita (1975)
 Verne Waite (1976) (Kauai)
 Tadao Nagashima (1975) (Hawaii)

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 Sakae Uehara (Maui)
 Shizuto Mizuire (Hawaii)

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 Noboru Oishi (1977) (University of Hawaii)
 Ralph Hale (1975) (University of Hawaii)
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 Tom Burch, Project Director, ex-officio, non-voting

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 Casimer Jasinski
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 Stanley Saiki
 Masaichi Tasaka, Hospital Association
 Livingston M.F. Wong, EMS Project Director, ex-officio nonvoting

Thomas Chang, City & County of Honolulu,
ex-officio nonvoting
H. Tom Thorson

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William Moore
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William Iaconetti
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John J. Lowrey

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J.I.F. Reppun
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Kenneth McCollum (Maui)
Peter Kim (Kauai)

PROCEEDINGS OF THE HOUSE OF DELEGATES

119th Annual Meeting of the Hawaii Medical Association

No scientific meeting was held in 1975 due to the imminence of the AMA Clinical Session starting on November 30 in Honolulu. The House of Delegates sessions were held on Saturday and Sunday, October 25-26, in the Mabel Smyth Building followed by the annual banquet at the Ilikai Hotel on Sunday evening. Fishing, golf, and tennis tournaments were held and prizes awarded at the annual Sportsmen's Nite Party held at the Mid Pacific Country Club on October 24.

The first session of the House of Delegates was called to order by President Winfred Y. Lee at 1:00 p.m., October 25, 1975, in the Mabel Smyth Auditorium.

Dr. R. Varian Sloan called the roll. Present were Drs. Winfred Y. Lee, William W.L. Dang, R. Varian Sloan, Grover H. Batten, Ruben Casile, Albert Chum-Hoon, Marion Hanlon, Verne Adams, Ann B. Catts, John Edwards, George Goto, J.I.F. Reppun, Arnold Siemsen, Peter Kim, Sakae Uehara, George H. Mills, Herbert Y.H. Chinn, John J. Lowrey, O.D. Pinkerton, Ben K. Azman, Charles W. Stewart Jr., Denis J. Fu, Ernest Bade, Frank Ferren, Rudolph Wipperman, Douglas B. Bell II, L.T. Chun, George Ewing, Vincent Aoki, William Davis, Reginald Ho, Gladys Fryer, Edward Kagihaara, Charles Judd, Roy Kuboyama, Andrew Morgan, Michael Okiihiro, Alan Pavel, John Watson, Theodore Tseu, Quintin Uy, Patrick Walsh, Neal Winn, Eugene G.C. Wong, and James Young.

Dr. Richard Ando was appointed parliamentarian. Drs. Roy Kuboyama and Eugene Wong were appointed sergeants-at-arms.

The minutes of the 118th Annual Meeting as published in the December 1974 issue of the Hawaii Medical Journal were approved as published.

The reports of the President, Secretary, Treasurer and component societies were included in the delegates handbook and referred as indicated. The resolutions were also assigned to reference committees.

Reference Committees were appointed as follows: Miscellaneous Business—George Goto (Chairman), John Edwards, Peter Kim, Neal Winn, Eugene G.C. Wong, and Marion Hanlon; Public Health—Sakae Uehara (Chairman), Roy Kuboyama, Vincent Aoki, Quintin Uy, Edward Kagihaara; Medical Education and Peer Review—Ann B. Catts (Chairman), Ernest Bade, Ben Azman, Reginald Ho, Alan Pavel, Patrick Walsh; Finance—Douglas Bell II (Chairman), Verne Adams, Denis Fu, Andrew Morgan, Michael Okiihiro, J.I.F. Reppun.

* * * * *

The Reference Committees were in session October 25 beginning at 1:45 p.m.

* * * * *

The second session of the House of Delegates was called to order on Sunday, October 26, 1975, at 10:00 a.m.

Hawaii delegate Frank Ferren and Honolulu delegate Charles Judd were absent the second day. Drs. Walter W.Y. Chang, Calvin Kam, James Lumeng, Stephen Tenby, and Henry Yokoyama were seated as delegates from Honolulu County.

* * * * *

PUBLIC HEALTH REFERENCE COMMITTEE

COMMISSION ON PUBLIC HEALTH

HOUSE ACTION: Adopted as follows:

The following are the Reports of the various Committees under the Commission of Public Health, Hawaii Medical Association.

Crippled Children Committee—

Dr. D.V. Reddy, Chairman

The Crippled Children Committee held three meetings during the year. Discussions focused on the state's Master Plan for Developmental Disabilities and Mental Retardation. Recommendations of the committee were sent to Council and subsequently to the Director of Health.

The Crippled Children's Branch of the Department of Health requested guidelines regarding tonsilectomies, indications for. A joint meeting was held with representatives of the EENT Society and appropriate guidelines were provided to this Branch.

Considerable discussion was held regarding the screening for metabolic disorders. No conclusion was reached. A subcommittee has been formed to look this over carefully and report back their recommendations.

The Chairman of this Committee appeared before the hearings of the Department of Health regarding DOH fees and indicated that the present 20% increase in DOH fees is unsatisfactory as it is only about 65% of the usual and customary fee and less than the current DSSH payment. It was indicated, however, that the Department of Health cannot do anything at present as this 20% increase is a legislative appropriation and any further change has to be brought about in the future through legislative action.

Communicable Disease Committee—

Dr. L.T. Chun, Chairman

Much of the year's activity centered around the Department of Health's mass immunization Catch-Up program during the school year 1974 through 1975. Free immunizations were given for diphtheria-tetanus, polio, rubella, and rubeola in the schools. As predicted, there was a good deal of confusion in record keeping and many children were given unnecessary boosters because of expediency. This Catch-Up program is to be the last one in the schools as far as mass immunizations if Act 51 is properly enforced this coming school year. Anyone in school would have benefited from the Catch-Up program and any new student entering must have completed his/her immunizations, physical examination, and tuberculin test per Act 51.

This Committee has reiterated that HMA does not favor mass immunization programs and that the role of the Department of Health is to seek out those who are deficient in their immunizations. In turn, they are to be referred to the proper agency or private physicians for their immunizations.

For similar reasons as the above, the Committee was not in favor of S.B. 654 which provided free immunizations to all children.

Chronic Illness Committee—Dr. Willard Miyahira, Chairman

Several meetings were held during the year, the majority of which revolved around the problems of aging.

Standardization for diabetes and hypertension screening was established, as requested by the State Department of Health, Chronic Disease section. Diabetes screening standard was adopted from previously established criteria of the American Diabetes Association (meeting of July 15, 1975). Criteria for hypertension was adopted from the standards previously established by the American Heart Association, as recognized by the the local Hawaii Heart Association (meeting of July 2, 1975).

In the area of aging, information obtained from the American Geriatric Society pointed out the problem of physician disinterest in the area of Geriatrics, and the need for more "day care" centers for the aged. An eventual goal of this Committee is to utilize the expertise of Lanakila Crafts, the Rehabilitation Center, and the Kuakini Day Care Center. Hopefully, a center for the aged would 1) free patients from Nursing Homes, whose only problem may be the need for care during the day while family members are at work, 2) utilize the expertise of the retired, who are still able to contribute to society. The possibility for federal funding for such a center was also entertained. These ideas are still in the discussion and study stage.

School Health Committee—Dr. Roy Kuboyama, Chairman

The School Health Committee engaged in the following

activities:

1. Reviewed the DOE Special Education Master Plan and advised the DOE on the medical aspect of it.
2. Informed the 1974 state legislators on the School Health Services Pilot Program so that the program will be expanded to all public schools in Hawaii over the next four years.
3. Tried to focus on "learning problems" by supporting the concept that the subject be on the program in the fall AMA Clinical Sessions in Hawaii.

Public Safety Committee—Dr. Truett V. Bennett, Chairman

The Public Safety Committee had no meetings during the past year.

Substance Abuse Committee—Neal Winn, M.D., Chairman

The members of the Substance Abuse Committee of the Hawaii Medical Association met several times during the past year. Activity centered primarily in the development of recommended HMA testimony with regards to proposed legislation; sponsorship of Dr. Robert Latta's attendance at the University of Utah's School of Alcoholism and Other Drug Dependencies in June 1975; endorsement of the University of Hawaii's recent workshop on alcoholism; and consideration of the activities of the State Substance Abuse Agency. Representatives from our committee have assisted the Department of Health in screening the candidates to serve as Executive Director of that agency in its new position as a branch within the Department of Health.

The committee has no recommendations requiring Council action at this time and is requesting no financial assistance for the forthcoming year.

Cancer Committee—Thomas Lau, M.D., Chairman

The Cancer Committee engaged in the following activities during the past year:

1. Participated in the administration of the Cancer Center of Hawaii through representation on the Executive Committee by the chairman of the Cancer Committee and three other HMA representatives.
2. Supported the Cancer Center of Hawaii in various proposals submitted to the National Cancer Institute.
3. Approved the co-sponsorship of the oncology course with the Cancer Center and University of Hawaii to be conducted for house staff, practicing physicians and others and collaborated with the Cancer Center on other future cancer seminars.
4. Participated in the acquisition of a blood cell separator to service the people of Hawaii. A unit is now available at both St. Francis and the Blood Bank of Hawaii both of which were acquired through donations and are being well utilized.
5. Voted not to support HB 382 (which required hospitals, skilled nursing facilities and intermediate care homes to report all patients in their facilities to the Tumor Registry) and HB 982 (which requires all physicians to report, in writing, to DOH information on every person with cancer under their care). It was felt that both bills were unnecessary as the present reporting is adequate.
6. Continued good working relationship with the Cancer Commission and the American Cancer Society.

Recommendations:

1. Continued participation in the administration and other activities of the Cancer Center of Hawaii.
2. Continue close working relationship with the Cancer Commission and American Cancer Society.

The chairman of the committee would like to officially thank the members of the committee and the secretary for their interest and cooperation.

The Commissioner of Public Health wishes to thank the Chairmen and committee members who have contributed to this report. It is heartening to see active communication among members of the committees with the various public and private agencies in areas of mutual concern. As medical programs and policies are being developed and planned, it is of utmost importance that these committees continue to openly express Hawaii Medical Association's

concerns on the health and welfare of the individual and his community.

CALVIN C.J. SIA, M.D.

CANCER COMMISSION

HOUSE ACTION: Adopted as follows:

The Cancer Commission met on eleven occasions during the past year. In addition, there were other meetings involving the chairman and Winfred Y. Lee, M.D., President of HMA; Lawrence Piette, Ph.D., Director of the Cancer Center of Hawaii; Audrey Mertz, M.D., Deputy Director of Health; and Thomas Burch, M.D., Project Director of the Hawaii Tumor Registry.

The year was a busy one. There were many routine requests for information for individual studies from the Cancer Center, and from many other projects which were reviewed and processed. The matter of a new contract for the HTR was also considered. In addition the commission considered two pieces of legislation, SB 982 and HB 1135 and voiced its disapproval of these bills.

One of the most serious matters for consideration concerned the chain of command and responsibility for the HTR. Through the efforts of your president matters were greatly improved. It was agreed by all parties that the Cancer Commission was the policy-making body for the HTR.

The Registry itself has been very busy carrying out its work and helping other hospitals either update or maintain their own registry material. Also, HTR is now able to prepare reports on selected sites for the hospitals on short notice.

The Registry continues to be the foundation on which many programs such as epidemiology, genetics, etc. stand among others. It has also been a most important ingredient in the preparation of studies of cancer of the breast, cervix, G.I. tract and others. It has contributed to the publication of "Cancer and the Five Continents" an international compilation of data from registries around the world. It is participating also on the state of asbestos workers in Hawaii for the Center of Disease Control in Atlanta. The HTR has also been the basis for the cervical cancer control project which is being planned and it is also going to be involved in the community breast cancer program.

Essential to the success of the Registry is the ability of registry personnel to travel to the neighbor island registries and travel to the mainland for workshops, special instruction, and SEER meetings. In the past, funds for this purpose have been provided by the American Cancer Society. This year, however, because the Society has been unable to make its contribution, the HMA Council appropriated \$5,000 so that travel obligations could be met. However, this fell short by approximately \$5,000 for the total needed for the balance of the year. There are still obligations for fiscal 1975 relating to SEER travel which must be met. Also, the American Cancer Society, Hawaii Division, is uncertain whether it can contribute monies to the HMA for this purpose in 1976. The Cancer Commission considers this matter a most serious one and recommends that the HMA assure the ability of registry personnel to meet required travel commitments. It also feels strongly that provisions be made in the 1976 budget for travel and publication funds up to a sum of \$10,000. Provision of this money would assure meeting essential commitments in the event that funding from the American Cancer Society, local trusts, and Foundations or other sources could not be obtained.

Recommendations:

- (1) That the House of Delegates authorize the expenditure of not more than \$3,000.00 for the balance of 1975 for the purpose of travel for HTR personnel, if funds are available.
- (2) That the House of Delegates authorize the HMA Council to approve funds for travel, publications, etc. of HTR personnel up to \$10,000 in 1976, if funds are available.
- (3) That these expenditures be made only if other sources of monies cannot be found.

GROVER H. BATTEN, M.D.

EMERGENCY MEDICAL SERVICES

HOUSE ACTION: Adopted as follows:

The Hawaii Medical Association—Emergency Medical Services (HMA-EMS) Program became operational in November, 1971 and has been progressing in phases since that time. This report will address the accomplishments of the HMA-EMS Program since June, 1974.

On June 28, 1974 a grant was awarded to the City & County of Honolulu under P.L. 93-151, Section 1203 for the establishment of an EMS System on the Island of Oahu. The total award was \$747,151. A portion of the implementation was subcontracted by the City & County of Honolulu to the HMA-EMS Program.

The accomplishments listed in this report are a result of a joint effort between HMA and the City & County of Honolulu.

The broad objective of the program has been to improve upon the present Oahu EMS Program in order that all people on the Island of Oahu will have easy access to and will receive prompt, efficient and effective emergency medical care when needed.

The following goals and objectives of the program were accomplished from July 1, 1974—June 30, 1975:

- (1) The EMS management organization was established through a subcontract from the City & County of Honolulu to the Hawaii Medical Association.
- (2) Types and numbers of manpower needed to implement an EMS system were identified.
- (3) Training programs for ambulance personnel (EMT & MICT), Emergency Room Nurses, Emergency Room Physicians and Public Safety personnel were developed and conducted.
- (4) "911" emergency call system was implemented on the Island of Oahu.
- (5) A mechanism to permit consumers to actively participate in determining the effectiveness of the system was developed and implemented.
- (6) The City & County of Honolulu ambulance dispatch radio system was improved.
- (7) A Statewide Standard inter-island transfer record, ambulance report form and ER record is available.
- (8) A consumer information and education program to meet the needs of Oahu's multi-ethnic groups was developed and implemented.
- (9) An evaluation system to determine patient management enroute, difficulties encountered during transport, adequacy of the ambulance equipment, personnel training and where future improvements of the entire system could be made was designed and implemented.
- (10) The eleven Oahu acute care medical facilities were reinventoried in order to assure continued compliance with the American Medical Association criteria.
- (11) the program continued to plan for future demands and needs of the populace for hospitals, clinics and rehabilitation centers.
- (12) Mutual and agreements were developed.
- (13) Appropriate legislation was introduced.
- (14) The fifteen (15) City & County of Honolulu ambulances were upgraded and two (2) additional vehicles were purchased.
- (15) Disaster plans were updated.

In order to assure the continuation of the Oahu EMS system, additional finances were sought by the City & County of Honolulu under P. L. 93-154, Section 1203 and from the Division of Associated Health Professions. On June 30, 1975 the City & County of Honolulu received Notice of Grant Awards totalling \$491,605. The funds included:

\$310,735.....for the establishment and operation
of an Emergency Medical Services
System on Oahu
\$ 93,777.....for the training of MICTs (Para-
medics)
\$ 87,093.....for the training of EMTs

A large portion of the implementation was subcontracted to

the Hawaii Medical Association to further improve the Emergency Medical Care System on Oahu.

In addition, the State Department of Health received a federal grant under P. L. 93-151, Section 1202 for the Planning of a Neighbor Island EMS System. The planning has been subcontracted to the Hawaii Medical Association.

All of the above mentioned grants began on July 1, 1975 and will continue through June 30, 1976.

It is anticipated that within the near future, an EMS system will be operational throughout the State of Hawaii.

WILLIAM DANG, M.D.

AMA DELEGATE

HOUSE ACTION: Adopted

The past eighteen months have been exceptionally busy for the officers, staff and members of your American Medical Association.

Difficult administrative decisions had to be made. The AMA membership was fortunate that realistic and practical leadership was available to make the decisions when necessary.

Early in 1974 it was very clear that the fiscal structure of AMA was unstable and that economic and structural reorganization was needed immediately.

The annual meeting in Chicago in June 1974 presented the forum for serious discussion and debate. The AMA leadership was questioned in depth regarding the operation of the AMA. The House of Delegates did not feel that the financial activities of the AMA were presented in enough detail. A confused House of Delegates was reluctant to endorse change without more information.

At the Clinical Session in Portland, Oregon, December 1974 the management-structure and fiscal problems of the AMA were discussed in greater depth as requested by the Delegates.

A \$60 mandatory assessment was passed by the House and the Speakers were directed to establish a Special Committee of the House which was charged with the following responsibilities:

Review—

- ... the financial affairs of the Association
- ... the Council and committee structure as it relates to fiscal matters
- ... the publishing activities and advertising
- ... and report their findings to the House at the annual meeting, Atlantic City, 1975

Also at Portland there was

- ... serious discussion regarding the medical injury insurance crisis. The question was asked how can the AMA help the practicing physician?
- ... deep concern regarding the HEW ruling on concurrent review of all hospital admission of medicare and medicaid patients
- ... a developing attitude in the House to challenge the MAC regulations and health manpower legislation.

The annual meeting in Atlantic City June 14-19, 1975, was packed with hard work and hard decision making. It was very obvious from actions by the House that they wanted stronger AMA involvement in problems facing the local practicing physician.

With standing acclamation, an overwhelming majority of delegates voted to raise AMA dues to \$250 for regular members. This will commence with fiscal year 1976. The House called for—

- ... rebuilding AMA on a sound financial basis. (This has already started on a full scale.)
- ... restructuring of the AMA organization. This too has already commenced (See AMA News 9-22-75)
- ... reshaping the AMA publications program. Decisions already made are to provide JAMA and American Medical News to all members without charge. The future of PRISM to be determined by the Board of Trustees. All specialty journals are by subscription.

Following the direction of the House to ease the malpractice crisis, the Board of Trustees during the first week of

September 1975 initiated action to establish a professional corporation to reinsure medical liability claims. The company the American Medical Assurance Corporation will reinsure AMA members whose state medical association has established their own medical liability insurance company.

The House

- ... strongly supported AMAs injunction against HEW regarding concurrent admission review
- ... was apprised that the offices of AMA General Counsel were advised by the Board of Trustees to develop legal groundwork against
- ... HEW regulations regarding "maximum allowable cost" (MAC) for drug purchasing
- ... Objectional features of health manpower legislation and
- ... PL 93-641 National Health Planning and Resource Development Act.

The progressive development I have outlined in this report clearly reflect the reaffirmation of confidence by the House in the AMA officers, Board of Trustees, and staff. It also reflects the new "fight" attitude of the AMA.

RECOMMENDATIONS:

(1) At an appropriate time prior to each annual and interim meeting of the AMA the president of HMA convene staff with association members who anticipate attending the meeting to caucus on issues pertinent to the general membership and medicine in Hawaii.

(2) That the HMA, through its Bureau of Research and Planning, develop long and short term goals and objectives regarding the Association's service to its members and citizens of the community including an outline of any fiscal commitments.

(3) The officers and council members of the HMA designate appropriate committees already within the association to apprise them on current action locally and nationally in the following areas: PSRO (Also include peer and fiscal review), Health manpower, National Health Insurance, PL 93-641 (National Health Planning and Resource Development Act). These appraisals should be kept current every three months—summarized and distributed to all members of the Association.

(4) Each member of the HMA is urged to exercise individual responsibility by keeping abreast of discussions and developments found in AMA and HMA publications.

GEORGE H. MILLS, M.D.

COMMISSIONER ON HEALTH SERVICE AND CARE

HOUSE ACTION: Adopted

Community Health Care

This Committee under Dr. George Mills started late but had several fruitful meetings evaluating problems and projects in this important area of health. Specifically, it discussed the National Health Planning and Resource Development Act (PL 93-641) but had no recommendations for now. It discussed the Waianae Coast Comprehensive Health Center but then referred the problem to Honolulu County Medical Society as it affects that county almost exclusively. The Committee discussed community professional directories and adopted the AMA judicial council position.

This committee recommended to the House of Delegates that the scope and responsibility of the Committee be more clearly defined. If the Committee continues, it will study the Comprehensive Health Plan and the National Health Planning and Resource Development Act further.

Health Manpower Committee

This Committee under Dr. Robert Nordyke met almost monthly and spent essentially the whole year gathering data on and evaluating the role of physician's assistants. It was agreed by the Committee that these should be defined as personnel who worked under the supervision and direction of a physician.

Discussions were held with several groups of special physician's assistants including nurses from the Neck and Back

Clinic at Straub Hospital and Pediatric Nurse Practitioners who do school-type examinations for low income families. Discussion was also held with an independently practicing psychiatric nurse but it was felt that she was not a physician's assistant because of her role independent of physician supervision. Considerable data on this subject was obtained but no specific recommendations were made by the Committee. It was generally agreed that the need for these workers would depend on the availability of physicians and some concern was voiced that with the growth of the University of Hawaii Medical School and resultant increase in physician supply, these jobs as physician's assistants might be restricted.

Testimony was submitted by the Commissioner to the 1975 State Legislature on a bill to start a Physician's Assistants Program at the University of Hawaii Medical School. The HMA's position was that the Medical School should concentrate on education of physicians and forget the Physician's Assistants Program for the present. The bill was subsequently dropped.

This Committee worked hard and should continue to meet gathering data and keeping abreast of this field. Several members of the Committee are now quite knowledgeable in this field of health manpower and could be good source material if there is a concerted effort either in the legislature or elsewhere to effect major changes in health manpower.

A Health Manpower Information System survey (by Ms. Ann Russell of the University of Hawaii in cooperation with the Committee) is being prepared to try to determine the needs in the State. It is to be a detailed survey but all the questions to be asked have not been finalized. It will need the cooperation of all physicians to derive meaningful data. This questionnaire will be sent to the HMA council for approval before it is disseminated as both the questions asked and answers received could have wide-spread impact.

Disaster

This Committee under Dr. John Edwards coordinated an airplane accident disaster exercise in October, 1974 involving the FAA, City and County Health Department, Oahu Civil Defense, EMS, Honolulu Airport, Honolulu Police Department, and various Honolulu Hospitals.

I feel the Committee should be continued and involved in some disaster exercise annually.

Recommendations

The Commissioner recommends:

1. The three Committees of the Commission should continue but that their roles be more clearly defined.

2. The Disaster Committee should be involved in some disaster exercise annually.

3. The Health Manpower Committee should continue to evaluate all aspects of health manpower needs in Hawaii. Areas for future study could be other health personnel including their need and education.

4. The Community Health Care Committee should continue to evaluate specific health care projects and plans such as HMO's, the Comprehensive Health Plan, etc.

5. These Committees should keep surveillance over these areas for HMA and should submit recommendations for action or act as source material as needed by HMA.

DOUGLAS B. BELL, II, M.D.

REPORTS OF THE COUNTY MEDICAL SOCIETY

HOUSE ACTION: Filed

Hawaii County

Although the majority of the Hawaii County Medical Society meetings were held in Hilo during 1974-75, meetings were also held in Waimea and Kona. Buses were chartered for the trips between Hilo and these outlying areas as was done the previous year. These monthly dinner meetings with various speakers on specialty topics continue to be the major activity of the Society.

In January, 1975, a Public Relations Committee was

formed to handle publicity releases concerning the medical profession and concerning new laws regulating medical practice.

As a result of the special meeting held in February, a poll, was taken to determine how physicians felt about the feasibility of having an acute care hospital in Hilo run by either the State or a private enterprise. The majority voted in favor to conduct an independent study on this matter. Most preferred that it be privately run.

A resolution was sent to Governor Ariyoshi urging the State to proceed with haste in building a security hospital for the safety and welfare of the community.

The Speakers Bureau that began in 1974 continues to be an active part of the Hawaii County Medical Society. To date we have had 20 speaking engagements as requested by various local community organizations.

Six new members have been added to the roster, making the total membership 76 for the Big Island. Hopefully, we will be able to recruit new members, as there are physicians who have recently begun practice on the island. The Medical Practice Committee had a difficult job this year, handling three cases, one of which is unresolved and referred to the HMA.

RUBEN CASILE, M.D.

Honolulu County

The Honolulu County Medical Society has instituted quarterly membership meetings. With the transfer of many of the county society functions to the State organization, the need for monthly meetings has not seemed to be necessary. The Board of Governors continues to meet at monthly intervals, however.

The program for the month of March featured as principal speaker, Governor George Ariyoshi, who gave his views on various subjects ranging from the Schools of Medicine and Law at the University of Hawaii to Agriculture. In answer to questions from the audience, Governor Ariyoshi stated that he would be willing to consider nominations from the HMA for positions on the Board of Medical Examiners and he emphasized that he would be looking to the HMA for advice and counsel on matters related to medicine and health problems. He stated that he hoped that the medical profession would recognize the need for employing the most experienced administrative people for his cabinet posts and that the appointment of Mr. George Yuen to the Department of Health was because he felt that he possessed this necessary administrative ability.

The next meeting in July was held before a standing room audience of over 350 in the Mabel Smyth Auditorium with Senator Dan Inouye speaking on medical malpractice. The Senator presented an excellent speech which impressed many of the members with his knowledge and depth of understanding in this very critical area.

In September, Mr. David Weihaupt, an executive with the American Medical Association, spoke on the re-organization of the AMA.

The Honolulu County Medical Society has approved a major fund-raising benefit for the Hawaii Medical Library. The Hawaii Medical Library has a significant debt and the dues paid by the Honolulu County Medical Society members which have been largely responsible in the past for support of the library have not been adequate to meet the needs for improvements and increased services. This benefit is scheduled for December 26, 1975 and will feature Mr. Sammy Davis, Jr., in an exclusive performance.

An amendment to the Bylaws of the Honolulu County Medical Society was passed at its September meeting. This allows nomination and election of the officers of the society by mail ballot and it is hoped will allow for fuller participation by the membership in the election process.

The Waianae Coast Comprehensive Health Center was again discussed by the Board of Governors. Testimony from interested parties was heard. The Society's Board of Governors decided to oppose in principle the concept of subsidized medicine. It did approve the request of the Center to nominate a physician to the Board of Directors of the Center from the Honolulu County Medical Society.

The Society has also been active with the Hawaii Medical Association in investigating various sites for a new facility to house the combined HMA-HCMS activities. Because of the lack of any funds it has not been possible for a building program to be started. It is to be hoped that funds can be raised to accomplish this goal.

ALBERT C.K. CHUN-HOON, M.D.

Kauai County

Bimonthly meetings of the Kauai County Medical Society were initiated on March 12, 1975, administered by duly elected officers consisting of Dr. V.C. Waite, President; Dr. R. Cruz, Vice President; Dr. T. Magoun, Secretary-Treasurer; Dr. P. Kim, continuing as councilman.

At its earliest meeting, a peer Review Committee, consisting of Dr. Robert Berry, Dr. Christoph Noll, and Dr. Patrick Aiu, were appointed and approved by the Society. In addition, the Kauai County Medical Society considered the desirability of an ad hoc committee to function as public medical information committee in general and to aid the local news media in truthful reporting of all related materials. Designated chairman was Dr. Roger Netzer with Drs. Chuang and Miyashiro as members.

This Society went on record early as supporting the development of PacPSRO and proceeded to institute such general policies within our respective hospital staff affiliations.

Considerable discussion in subsequent meetings was devoted to the problem of malpractice insurance coverage. One meeting was designated specifically since it was our pleasure to hear local citizen and retired chief of anesthesiology from UCLA, Dr. John Dillon. Dr. Dillon discussed in depth the principle of "before the fact" compulsory arbitration as a better or possibly the best method of dealing with so-called malpractice problems and means of financial coverage.

A most fruitful comprehensive discussion of the entire malpractice subject was held on September 10 at which time President Dr. W. Lee with Dr. William Dang, Dr. Albert Chun-Hoon, Dr. David Weihaupt from AMA and Mr. Thorson were guests and provided considerable first-hand information on progress made at the State level.

Eight new members were added to the roster of the Society during the year, bringing the total membership to 42. Approximately 70% of the membership attended most meetings during the year.

The outgoing President has recommended that the Society consider as number one project during the coming year 1976 a detailed revision of the Society's existing constitution and bylaws. Further, that the membership participate more extensively in continuing medical education and contribute to hospital inservice training programs, whenever possible.

VERNE C. WAITE, M.D.

Maui County

The Maui County Medical Society held meetings regularly throughout the past year, combining clinical and business sessions in each meeting. Of special concern the past year has been the problem of physicians liability insurance and the President of the local Bar Association spoke at one meeting. Another area considered was that of unified membership and a poll of members showed a majority of those responding to be in favor of separating County-State membership from AMA membership.

Another meeting was devoted to legislative concerns which were discussed with Legislators from Maui County, who were our invited guests.

A joint meeting with the Dental Society was held and a special meeting was called to meet with the AMA and HMA representatives.

Officers for 1975 were: President, Marion Hanlon, M.D.; Vice President, William C. James, M.D.; Secretary-Treasurer, William G. Kepler, M.D. Delegates were Dr. Denis Fu, Dr. Ben Azman and Dr. William Hoskinson. Alternate were: Dr. Alfred Burden, Dr. Jose Romero and Dr. Charles Stewart. Councilor was Dr. Sakae Uehara.

MARION HANLON, M.D.

LEGAL COUNSEL

HOUSE ACTION: Filed

This report covers the 12 month period (September, 1974 to August 1975) during which your legal counsel attended the Council meetings, and handled administrative calls, correspondence, and matters for the Association as required by your staff and officers.

The subjects on which we conferred included questions on the liability for theft from the 1974 convention, the pension plan, the then existing litigation against the Scientologists, pending and proposed legislation, the Tumor Registry, the malpractice insurance crisis and planning relating to HMA's proposed positions, the process of formation of a mutual casualty insurance company, the association bylaws and miscellaneous matters including PSRO and EMS activities and certificate of need procedures.

Services were provided in relation to acquiring new office space.

Your legal counsel has no recommendations.

V. THOMAS RICE

RESOLUTION NO. 5—Objecting to Proposed HMO Amendments

HOUSE ACTION: Adopted

WHEREAS, PL 93-222, the Health Maintenance Organization Act of 1973 had as one of its reported advantages the "fundamental incentive to both keep its members healthy and control its costs" and

WHEREAS, the Act states that an HMO is an entity which "provides basic and supplemental health services to its members." Premiums for basic and supplemental services be provided on "a community rating system." Basic services be provided by health professionals "who are members of the staff" of the HMO and whose members "as their principal professional activity" and as a group responsibility engage in coordinated practice of their profession for a health maintenance organization, and

WHEREAS, HR 7847, the Health Maintenance Organization amendments of 1975, attempt to change the act and gut the HMO concept by

- ...eliminating certain basic services such as preventive health care
- ...making supplemental services optional
- ...deleting open enrollment
- ...removing the requirement that a medical group be previously engaged in providing service to an HMO
- ...deleting the requirement that loan guarantees be made only to those entities in medically underserved areas; so therefore be it

RESOLVED, that the House of Delegates at this annual meeting of HMA strongly object to the proposed amendments of PL 93-222 since it changes the comprehensive concept of the act, allows government to support one health care delivery concept over others and relegates the individual private practice of medicine to a second choice position, and be it further

RESOLVED, that the leadership of this association inform our national Senators and Representatives of our concern and encourage them not to support HR 7847 amendments.

GEORGE H. MILLS, M.D.

RESOLUTION NO. 11—Hawaii Foundation for Medical Care

HOUSE ACTION: Adopted

WHEREAS, the pluralistic approach to health and accident insurance programs is supported by the Hawaii Medical Association, and

WHEREAS, big government and certain insurance companies apparently prefer a more monolithic non-competitive approach, and

WHEREAS, The Hawaii Foundation for Medical Care Inc. is a physician-sponsored non-profit subsidiary of the HMA, and

WHEREAS, this plan embodies concepts, coverage and cost predictability that Hawaii's physicians have determined is best for their patients, and

WHEREAS, the Foundation Plan is statewide and includes specialists and generalists who support the free enterprise concept, and

WHEREAS, now that the Health Maintenance Organization basic concepts are being modified and liberalized, so therefore be it

RESOLVED, that the Board of Directors of the Hawaii Foundation for Medical Care explore the possibility of functioning as a true statewide HMO which will provide the citizenry of Hawaii another choice in health and accident insurance coverage.

GEORGE H. MILLS, M.D.

RESOLUTION NO. 7—Health Manpower Legislation

HOUSE ACTION: Adopted

WHEREAS, the control of any enterprise can be accomplished thru the control of its manpower, and

WHEREAS, legislation now in Congress attempts to control medical manpower and distribution by

- ...requiring medical schools, in order to receive capitation grants, to take from each student an agreement to repay the per capita funding which the school receives from the federal government. The student has the option of service in shortage areas in lieu of such payment (H.R. 5546)
- ...Ordering schools of medicine that to be eligible for capitation grants, they would have to assure the Secretary of HEW prior to the students admission that the student will enter into a written agreement to practice for two years in a medically underserved area providing their services as full time practitioners of family medicine, general pediatrics and general internal medicine (S 1357), therefore be it

RESOLVED, that the delegates at this convention reject this type of Congressional action and that our Congressional delegation be informed of the action of this House, and be it further

RESOLVED, that the Health Manpower Committee of HMA meet with representatives from the University of Hawaii School of Medicine, medical student, intern and resident organizations in an attempt to assist and obtain their views on this issue.

GEORGE H. MILLS, M.D.

RESOLUTION NO. 8—Teenagers and Sports

WHEREAS, there is increasing national and local concerns regarding the dangers of contact sports, and

WHEREAS, there are approximately 60,000 male students in the 8th through the 12th grade in Hawaii's public and private schools who could participate in football and other contact sports, therefore be it

RESOLVED, that the Hawaii Medical Association create a committee on sports medicine, and be it further

RESOLVED, that this committee develop general guidelines that can be utilized to promote safety in sports.

GEORGE H. MILLS, M.D.

RESOLUTION NO. 12—Counselors and Educators in Human Sexuality

HOUSE ACTION: Not Adopted

WHEREAS, the committee on Human Sexuality of the American Medical Association believed it proper to review this complex facet of human behavior and publish Human Sexuality in 1972, and

WHEREAS, the American Association of Sex Educators and Counselors has prepared national certification standards, and

WHEREAS, there seems to be confusion in the State of Hawaii as far as its citizens are concerned regarding quali-

fications of therapists offering these services.

RESOLVED that the Hawaii Medical Association evaluate available standards of practice in other states, and in so doing offer quality referred resources to HMSA and other organizations.

RALPH W. HALE, M.D.

RESOLUTION NO. 13—Concerning Restrictive Regulations at Skilled Nursing Facilities

HOUSE ACTION: Not Adopted

WHEREAS the rules and regs of DHEW and of the State DOH place an excessive burden on all health personnel associated with the transfer of patients to, and of patients care within SNF's, and

WHEREAS a complete history and physical examination *must* be repeated on such patients if a prior one was done more than 5 days before; a patient *must* be formally discharged from an acute care hospital before being as formally admitted to an SNF, with tremendous attendant paper work and record keeping; orders *must* be recapped once a month, with great potential for serious error, extra work on the part of the nurses on behalf of doctors who have little time to be doing it themselves; a physician *must* see the patient once a month at least, whether that patient needs the costly professional visit or not; an attending physician *must* make a special trip (another costly professional visit) within 48 hours of giving a telephone order to a charge nurse, simply to append his name to the chart; a physician *must* initiate a "patient care plan", although there is no necessity to make a "graduation ceremony" out of continuing care that should flow smoothly from acute care to extended care; a physician *must* review the diagnosis once a month, which list of problems hardly ever changes and only rarely requires additions or subtractions; all of these requirements add immeasurably to the work effort, time expenditure and cost *without* significantly contributing to the patient's well-being or health, and

WHEREAS the total net objective of these rules and regs is obviously to withhold the benefits to which eligible patients are entitled by law, thus attempting unsuccessfully to cut costs under the specious rationale of "up-grading the quality of medical care", and

WHEREAS these rules and regs, therefore, *add* to the overall costs of medical care of such patients, and particularly those who receive public assistance under one program or another, and

WHEREAS these rules and regs infringe on the rights of patient and doctor, infringe on the practice of medicine and the one-to-one relationship of patient-to-physician, now, therefore, be it

RESOLVED, that the HMA stand up to government and convey to it the sense of its House of Delegates here assembled, that we oppose the implementation of these costly rules and regs, and be it further

RESOLVED, that the transition between acute and extended care facilities be made more smooth, easy and effortless for patients and personnel, and be it further

RESOLVED, that the rules and regs within SNF's be amended radically so as to take the load off attending health care personnel and to permit more direct care of the patient by a staff that is almost invariably more than dedicated to their helpless patients.

J.I.F. REPPUN, M.D.

PUBLIC LAW 93-641

HOUSE ACTION: Adopted As Follows

On January 4, 1975 President Ford signed PL 93-641 into Law. In late January a seminar in San Francisco was held by DHEW, Region IX, which Drs. Herbert Chinn, William Dang, Winfred Lee and Henry Oyama along with Mr. Jon Won attended.

Subsequently, Drs. Chinn and Dang served on the Governor's Ad Hoc Committee for area designation. This committee had recommended to the Governor of the State of

Hawaii that Hawaii be designated as one Health Service area which would mean that Hawaii is to have a Health Service Agency and a State Agency. Initially the Governor accepted this recommendation but as noted later in this report, the Governor is asking for a State Agency only.

The remainder of this report summarizes PL 93-641.

Public Law 93-641, the National Health Planning and Resources Development Act of 1974 replaces Comprehensive Health Planning, Regional Medical Programs and the Hill-Burton Facilities Construction Authority with a State Health Planning and Development Agency which will include a new program for medical facilities, construction and modernization and Health Systems Agencies to do planning and to disburse funds to implement the plans.

The Legislation has two principal parts. The first, a new Title XV in the PHS Act, revises existing health planning programs, all of which expired June 30, 1974. The second, a new Title XVI in the PHS Act, revises existing programs for the construction and modernization of health care facilities, which also expired June 30, 1974. Title XVI also provides funds to the health systems agencies for their use in the development of health resources which will implement their plans.

Health service areas will be made up of geographic regions based on factors such as population and availability of resources to provide all necessary health services for residents of the area. After consultation with the Governor of the State, the Secretary of HEW must designate either a private nonprofit corporation or a public entity as the health system agency (HSA) responsible for health planning and development in that area. A health systems agency (HSA) may not be or operate an educational institution. The legislation specifies minimum criteria for the legal structure, staff, governing body, and functioning of the health systems agencies. They would be generally responsible for preparing and implementing plans designed to improve the health of the residents of their health service area; to increase the accessibility, acceptability, continuity, and quality of health services in the area; to restrain increases in the cost of providing health services; and to prevent unnecessary duplication of health resources.

The functions of the Health Systems Agencies (HSA) are to

- gather and analyze suitable data;
- establish health systems plans and annual implementation plans;
- provide either technical and/or limited financial assistance to people seeking to implement provisions of the plans;
- coordinate activities with PSRO's and other appropriate planning and regulatory entities;
- review and approve or disapprove applications for Federal funds for health programs within the area;
- assist States in the performance of capital expenditures reviews;
- assist States in making findings as to the need for new institutional health services proposed to be offered in the area;
- assist States in reviewing existing institutional health services offered with respect to the appropriateness of such services; and
- annually recommend to States projects for the modernization, construction and conversion of medical facilities in the area.

The Act also requires the Secretary of HEW to designate an agency of State government (chosen by the Governor in each state to serve as the State health planning and development agency (State Agency). This State Agency is to be advised by a Statewide Health Coordinating Council (SHCC) whose composition and responsibilities are specified in the Legislation.

The functions of the State agency include:

- conducting the State's health planning activities and implementing the parts of the State health plan and plans of health systems agencies which relate to the government of the State;
- preparing a preliminary State plan for approval or disap-

proval by the Council;

- assisting the Council in the review of the State medical facilities plan and in the performance of its functions;
- serving as the designated planning agency under Section 1122 of the Social Security Act if the State has made an agreement and administering a State Certificate of need program of comparable scope;
- reviewing new institution health services proposed and making findings as to the need for such services; and
- reviewing existing institutional health services offered with respect to the appropriateness of such services and making public its findings.

This act also provides assistance through allotments, loans, loan guarantees, and interest subsidies for projects for the following:

- Modernization of medical facilities,
- building new outpatient medical facilities,
- building new inpatient medical facilities in areas which have experienced recent rapid population growth,
- converting existing medical facilities for providing new health services.

Besides including grant assistance for construction and modernization projects for eliminating or preventing safety hazards and complying with licensure or accreditation standards, this Act authorizes grants to Area Health Service Development Funds and appropriations for transition of existing planning and related programs to the new system established under the Act.

Section 1536 of the Act provides that any state that has no county or municipal public health institutions or departments and has prior to 1-1-75 maintained a health planning system which substantially complies with the purposes of the act, shall not have a health services area established within it and shall not have a Health Systems Agency designated for it. The Governor of the State of Hawaii has asked the Secretary of HEW for such a waiver for Hawaii under this section and if granted, the State Agency will then perform all the functions named in the act and receive all funds authorized for both agencies.

Recommendations:

- (1) HMA should apply for a planning grant for forming a HSA.
- (2) HMA should reiterate its stand on designation for Hawaii as one health service area.
- (3) As many members of HMA as possible should get involved in local planning under PL 93-641.

WILLIAM W.L. DANG, M.D.

RESOLUTION NO. 18—Pediatric Screening Exams (EPSDT)

HOUSE ACTION: Adopted as follows

Be it resolved, that it is the policy of the Hawaii Medical Association that pediatric screening examinations, immunizations and tests required by public agencies should whenever possible be delivered through the child's regular physician in order to assure continuity of care.

Be it further resolved that if it should be necessary for a governmental department or agency to hire a physician to see patients, all qualified physicians should be informed and given an opportunity to apply to participate.

THATCHER MAGOUN, M.D.

RESOLUTION NO. 19—A "Medical Home" for All Children

HOUSE ACTION: Adopted

WHEREAS the Kauai Medical Society has taken a stand that public agencies should refer all children coming under their jurisdiction for health care: Screening, immunization, and follow-up on any health medical problems discovered, to private physicians (the family's usual source of medical care in most instances), in order to maintain continuity of care in sickness and in health, and

WHEREAS both Federal and State sources of funds are

available for reimbursement to physicians who give such care, and

WHEREAS the present system of government clinics or contracted services provide fragmented attention to the child, poor communication with the PMD, a scattering of records and no continuity of the important one-to-one relationship, and

WHEREAS there have been improprieties in hiring practices without adequate public hearings or public disclosure of available positions, now, therefore, be it

RESOLVED, that the HMA support the Kauai Medical Society in its stand, and be it further

RESOLVED, that this sense of the House of Delegates be communicated to the Director, Department of Health.

J.I.F. REPPUN, M.D.

RESOLUTION NO. 21—Neighbor Islands Emergency Medical Services System

HOUSE ACTION: Adopted as follows

WHEREAS the Hawaii Medical Association through its Emergency Medical Service program has planned and implemented on the island of Oahu an outstanding program for extending emergency care to our citizens and

WHEREAS the Hawaii Medical Association is currently engaged in planning for a similar program to be developed on the neighbor islands, now therefore be it

RESOLVED, that the Hawaii Medical Association express its willingness to assume the responsibility of a contract to develop and implement any mutually acceptable portions of the Emergency Medical Services System for the Neighbor Islands.

WILLIAM W.L. DANG, M.D.

MEDICAL EDUCATION AND PEER REVIEW

COMMISSION ON PEER REVIEW AND MEDICAL EDUCATION

HOUSE ACTION: Adopted. The delegates voted further to refer a recommendation on continuing medical education as a condition of HMA membership to the Bylaws Committee.

The Committees under this commission have each met at least once during the past year, and most have been meeting regularly.

Publications Committee has been actively re-organizing the Hawaii Medical Journal with an emphasis on education and information. The financial status of the Journal has been improved and the Publications Committee has had several meetings with the Finance Committee.

Maternal and Perinatal Mortality Study Committee continues to receive assistance from the State Department of Health in obtaining the information and statistics necessary for case investigations. Seven maternal deaths were reviewed and classified by the main committee, and the Steering Committee (subcommittee on perinatal deaths) met regularly to review cases, fourteen of which were referred to the main committee.

Professional Liability Committee continues to be a very active review committee with the important responsibility of trying to determine physician insurability. Recommendations from this committee are forwarded to the malpractice insurance carrier.

Peer Review Committee met only once this year to consider a request to review a case previously referred to a county society peer review committee. The HMA Peer Review Committee meets on call and is the appeal committee for the county society peer review committees. It also acts as an informational source for the county societies.

Medical Education Committee met regularly during the first half of the year but has met infrequently recently due, in part, to a personnel change. Review and certification of

hospital programs for Continuing Medical Education accreditation were performed at six hospitals, one specialty society and one voluntary health organization. Other such programs will be ready for review in the near future. The increasing importance of categorizing, and certifying continuing medical education programs, and of establishing and standardizing a system for providing evidence of CME for individual physicians, will place heavy demands on this committee and on the HMA as a whole. Whether physician CME Certification through the AMA Physician's Recognition Award or other similar programs becomes mandatory or remains voluntary, it is necessary for the HMA to maintain the initiative in establishing criteria for satisfying physician CME. It is also essential that the HMA encourage and invite advice and assistance from the University of Hawaii Medical School, and the specialty societies in developing the requirements and methods of certification for physicians and programs. With this in mind, it would seem most appropriate to remove the Medical Education Committee from this Commission, and establish a separate Commission on Continuing Medical Education with representatives from the University of Hawaii and the specialty societies. The Commission would be directly responsible to the HMA Council. Because of the expanding duties of this Commission and with the anticipation of an increasing workload in record-keeping, both staff and professional time-commitments will be heavy and may require remuneration and budgetary adjustments. Whether a program for providing evidence of physician compliance with CME requirements is supported financially solely by the physicians or receives other monies should be investigated by the HMA-CME Commission together with the HMA Finance Committee.

Recommendations:

1. That the Hawaii Medical Journal be published on a monthly basis during 1976.
2. That the House of Delegates approve the proposal for the perinatal mortality surveillance as adopted by the Maternal & Perinatal Mortality Study Committee. (The proposal sets forth weight, age, cause of death, and other statistical criteria and establishes a mechanism for review. The proposal was developed by Dr. Joan Hodgman, neonatologist at Children's Hospital, and Dr. Thomas Burch of the State Department of Health).
3. That the Medical Education Committee be removed from Committee status, and become a separate Commission of the HMA, directly responsible to the HMA Council; and
 - a. That this new Commission be called the Commission on Continuing Medical Education of the HMA.
 - b. That the Commission be expanded to include representatives from the University of Hawaii Medical School and the specialty societies, the chairman to be appointed by the HMA President.
 - c. That the Commission be responsible for:
 - 1) Developing criteria and standards, and implementing a program for verifying continuing medical education of physicians
 - 2) Certification of programs throughout the state for CME credits
 - 3) Providing a central scheduling service to maintain a calendar of CME events and assist in minimizing conflicts in scheduling
 - 4) Providing a resource or informational center on CME for all physicians and other interested parties in the state
 - d. That the Commission be allowed a budget of \$12,000 for 1976 and that it meet with the Finance Committee by July 1976 to discuss future budgetary requirements and resources.

ANN B. CATTS, M.D.

AD HOC COMMITTEE MEDICAL MALPRACTICE

HOUSE ACTION: Adopted As Follows

This committee was appointed by H.M.A. President, Dr. Winifred Lee, early this year in order to study the many issues regarding medical malpractice. Its task was to prepare and submit policies to the HMA Council for approval. These policies would then represent the official position of the Hawaii Medical Association regarding medical malpractice.

The committee met on a number of occasions and reviewed legislation passed by other states as well as model legislation proposed by the American Medical Association, and studied the problems unique to Hawaii.

The importance of having a united viewpoint to represent organized medicine within the state was realized. The necessity for this unity is underscored by the fact that the next legislative session of our State will be concerned with laws to attempt to alleviate the malpractice crisis. The HMA has been given representation on a committee formed by the Department of Regulatory Agencies to produce an Omnibus Bill which will be presented to the next State legislative session. Representing the HMA on this Committee are Dr. Alan Pavel, Mr. Tom Thorson and Dr. Albert Chun-Hoon. The sixteen members include the Director of the Department of Regulatory Agencies who is the Insurance Commissioner, his Deputy, insurance industry representatives, defense and plaintiff's attorneys, consumer representatives and the above mentioned three representatives from HMA.

The HMA Ad Hoc Committee on Medical Malpractice approached the problems by dividing them into two separate headings: (1) The issues which would change the present tort systems to a medical review panel, shorten the statute of limitations, limit attorney's contingency fees, impose compulsory binding arbitration, allow a collateral source disclosure rule, and define more clearly "Res Ipsa Loquitur", "informed consent", and eliminate the "Ad Damnum Clause". (2) A revision of the medical practice act to strengthen the Board of Medical Examiners.

All of the issues have been presented to the council and have been approved in principle. These issues have also been circulated to the membership of the HMA by Dr. Winifred Lee for informational purposes, and to request their opinions and recommendations. These policies are attached.

At the request of Argonaut Insurance Company's local agent, Mr. Hugh Singrey, a meeting was held with the Hawaii Society of Anesthesiologists regarding possible methods of reviewing anesthesia complications and improving anesthesia practice to reduce risks in that field. A meeting was held with the attendance of Dr. Arthur Sprague, President of the local society and 7-8 members of the society with Drs. Ann Catts, Alan Pavel, and Albert Chun-Hoon. The Anesthesiologists were requested to meet and submit recommendations to the House of Delegates for implementation through the HMA.

Recommendations:

- (1) That the HMA House of Delegates approve the policies printed below as submitted by the Ad Hoc Committee on Medical Malpractice and passed by the HMA Council.
- (2) That these policies become the official position of the HMA to represent the views of the Association in the next legislative session of the State of Hawaii.

ALBERT C.K. CHUN-HOON, M.D.

APPENDIX A—HMA Legislative Proposal On Medical Malpractice

August 27, 1975

MEMORANDUM

TO: All Members of the Hawaii Medical Association
FROM: Winifred Y. Lee, M.D., President

This report is in regard to your HMA position on the important issue of malpractice insurance problems. This report is based on the deliberations of the Ad Hoc Committee on Medical Malpractice chaired by Dr. Albert Chun-Hoon and

the position taken by our HMA Council relative to this issue.

The following is a resume of our position regarding legislative proposals designed to make changes in our statutes pertinent to the medical malpractice problem. It should be noted that the following position is presented to you in general terms and no attempt has been made to reduce these items of concern to legal language. We are attempting to delineate certain principles for the consideration and information of our entire membership since we realize the importance of this issue to all of us. Details of these positions can later be further clarified and, perhaps, even changed when one goes through the legislative process. It should be remembered that this is the present HMA position, and hopefully, will attempt to provide a solution to a very complex problem. This is the beginning.

- (1) **COMPULSORY BINDING ARBITRATION** through a board or commission composed of physicians, lawyers, and a judge with the authority of a circuit court. This board will consider all cases reviewed by the Hawaii Medical Association through its county medical society peer review committees and the findings of the county medical society peer review committees will be admissible as evidence. From the Board's decision, appeal can be made directly to the Supreme Court on matters of law, but not on findings of fact.

The Board or commission may:

- a. Appoint experts to review medical fact.
 - b. Approve all contingency fee arrangements.
 - c. Call for independent medical examination of plaintiff.
 - d. Determine amount of damages.
 - e. Determine mode of payment—lump sum or monthly payments from a trust.
- (2) Revision of **STATUTE OF LIMITATIONS** providing that actions must be filed:
 - a. 1 year from time of discovery or
 - b. 2 years from occurrenceregardless of minority or other legal disability.
EXCEPT
 - a. Minors have until two years after their sixth birthday to file.
 - b. In case of foreign objects negligently left in patient, then one year from discovery.
 - (3) We support an **OCCURRENCE TYPE POLICY** and oppose a "claims-made" policy form. (The occurrence type policy is the present type of policy now generally in use that provides coverage for events that occur during the policy year; for example, if the event occurred in 1970 and you were sued in 1972, you are covered even if you are not insured in 1972. A claims-made policy covers the insured for only claims filed during the policy year; that is, if the event occurred in 1970 and you were sued in 1972, you would not be covered unless you were still insured by the same carrier in 1972.
 - (4) We propose a **MAXIMUM MONETARY LIMIT** on the amount awarded.
 - (5) A **COLLATERAL SOURCE LAW** that would provide for consideration to be given to all other sources of compensation in computing the total award for a given case.
 - (6) Revision of the **IMPLIED WARRANTY** provision to require that any warranty must be in writing.
 - (7) We propose that **INFORMED CONSENT** be based on a document drafted by the Hawaii Medical Association, Hawaii Hospital Association, and Hawaii Bar Association which when signed by the patient would be evidence of proper consent.
 - (8) We will recommend that the arbitration board review **CONTINGENCY FEES** to be based on a sliding scale not to exceed a specified maximum amount.
 - (9) Eliminate the **AD DAMNUM CLAUSE** which in plain language means that the complaint cannot specify the amount of monetary damages for which suit is being filed.
 - (10) We oppose the **NO-FAULT** system because of the significant cost of this approach since this implies that monetary damages will be paid not only for malpractice

costs but also for mal-occurrence costs not due to negligence.

In addition to the above legislative approaches to the malpractice problem, the Council has also agreed to a commitment by our Association to report all peer review findings where incompetence or negligence on the part of the physician is questioned. The following is the action taken by the Council:

"That all cases of apparent negligence and possible malpractice involving serious question of competence on the part of a physician must be submitted for peer review by the county medical society. If disciplinary action by the county medical society is indicated, the case shall be referred to the Peer Review Committee of the Hawaii Medical Association. The conclusions of the committee's deliberations, if they indicate that the conduct or professional competence of the physician is inappropriate, will be transmitted to the Board of Medical Examiners. Due process will be followed at all levels."

This policy is a voluntary attempt to continue the availability of the best medical care for the patients of Hawaii.

Each and every one of us can help in the malpractice problem by:

- Improving our communication and rapport with our patients.
- Being honest with patients about expected outcome.
- Being sure that your front office handles all patients with courtesy and dignity.
- Knowing your limitations and when to refer.
- Upgrading your performance by participating in continuing medical education.
- Not publicly criticizing a colleague's methods.
- Practicing the best medicine you know how.

THE EXERCISE OF OUR BASIC MEDICAL PRINCIPLES AND ETHICS WILL ASSURE THE BEST PHYSICIAN-PATIENT RELATIONSHIPS.

Any comments relative to these HMA policies on this important issue should be directed to your Council members or to the HMA Office. Further actions on this subject will be related to you through the Hawaii Medical Journal.

Sincerely,

/s/ WINFRED Y. LEE, M.D.
HMA President

APPENDIX B—Recommendations Of The Subcommittee On The Medical Practice Act

The Medical Practice Act of Hawaii has been reviewed in detail along with the statutes of other states. The committee recommends the following changes:

Section 453-1: Recommend that the following clause be **DELETED**

"... provided that when a duly licensed physician pronounces a person affected with any disease hopeless and beyond recovery and gives a written certificate to that effect to the person affected or his attendant nothing herein shall forbid any person from giving or furnishing any remedial agent or measure when so requested by or on behalf of the affected person."

Section 453-3.1: **DELETE** entire section. This section of the law was added by the 1969 State Legislature especially for a specialist in hyperbaric medicine from Sweden. The physician for whom the law was created did not come to Hawaii to practice.

Section 453-5 Board of medical examiners; appointment, removal, qualifications. There are presently seven members of the board who are appointed by the governor with the confirmation of the Senate. The board serves without pay except for reasonable travel expenses and other expenses incurred in the discharge of their duties. Committee recommends

(I) Appointments to the Board be made by the governor from a list of nominees elected by the component county

medical societies and submitted by the Hawaii Medical Association. A nominee need not be a member of the Hawaii Medical Association;

- (2) That two additional members of the board be appointed to represent the legal and ecclesiastical community;
- (3) That an adequate budget be assured for the operation of the board including adequate staff assistance and travel expenses and per diem for board members.

Section 453-6 Fees; expenses, renewal of licenses. Committee recommends that evidence of continuing medical education as determined by the HIMA be submitted with the fee for renewal of license every three years. The HIMA in designing the requirements, may consult with appropriate organizations or associations. The CME requirements for relicensure shall not begin until four years after the Act is changed. *Section 453-8 (Additions are capitalized) Revocation, suspension OR LIMITATION of licenses.* Any license to practice medicine and surgery may be revoked or suspended OR LIMITED by the board of medical examiners at any time in a proceeding before the board for any one or more of the following acts or conditions on the part of the holder of such license:

- (1) Procuring, or aiding or abetting in procuring, a criminal abortion;
- (2) EMPLOYING ANY PERSON TO SOLICIT PATIENTS FOR HIM;
- (3) Obtaining a fee on the assurance that a manifestly incurable disease can be permanently cured;
- (4) Wilfully betraying a professional secret;
- (5) Making any untruthful and improbable statement in advertising one's medical or surgical practice or business;
- (6) False, fraudulent, or deceptive advertising; (Delete present (7) re regulation of menses)
- (7) Being habitually DRUNK OR BEING OR HAVING BEEN ADDICTED TO, DEPENDENT ON, OR A HABITUAL USER OF NARCOTICS, BARBITURATES, AMPHETAMINES, HALLUCINOGENS, OR OTHER DRUGS HAVING SIMILAR EFFECTS;
- (8) PRACTICING MEDICINE WHILE THE ABILITY TO PRACTICE IS IMPAIRED BY ALCOHOL, DRUGS, PHYSICAL DISABILITY OR MENTAL INSTABILITY;
- (9) Procuring a license through fraud, misrepresentation, or deceit, OR KNOWINGLY PERMITTING AN UNLICENSED PERSON TO UNLAWFULLY PERFORM ACTIVITIES REQUIRING A LICENSE;
- (10) Professional misconduct or gross carelessness or manifest incapacity in the practice of medicine or surgery INCLUDING:
 - (A) ANY CONDUCT OR PRACTICE CONTRARY TO RECOGNIZED STANDARDS OF ETHICS OF THE MEDICAL PROFESSION OR ANY CONDUCT OR PRACTICE WHICH CONSTITUTES A DANGER TO THE HEALTH OR SAFETY OF A PATIENT OR THE PUBLIC OR ANY CONDUCT, PRACTICE, OR CONDITION WHICH IMPAIRS A PHYSICIAN'S ABILITY SAFELY AND SKILLFULLY TO PRACTICE MEDICINE;
 - (B) WILFUL PERFORMANCE OF ANY SURGICAL OR MEDICAL TREATMENT WHICH IS CONTRARY TO ACCEPTABLE MEDICAL STANDARDS; AND
 - (C) WILFUL AND CONSISTENT UTILIZATION OF MEDICAL SERVICE OR TREATMENT WHICH IS CONSIDERED INAPPROPRIATE OR UNNECESSARY.
- (11) Violation of the conditions or limitations upon which a limited and temporary license is issued.

If any such license is revoked, suspended OR LIMITED by the board for any act or condition listed in this section, the holder of the license shall be in writing notified by the board of the revocation or suspension. Any license to practice medicine and surgery which has been revoked under this section may be restored by the board of medical examiners. ADD new Section 453-A—VOLUNTARY LIMITATION OF

LICENSE. A physician may request in writing to the Board a limitation of his license to practice. The board may grant such request for limitation and shall have authority, if it deems appropriate, to attach conditions to the license of the physician. Removal of a voluntary limitation on licensure to practice shall be determined by the board.

ADD new Section 453-B—REVIEW OF ADVERSE DECISIONS REPORTED BY PEER REVIEW COMMITTEES OF THE MEDICAL SOCIETIES, HOSPITALS, AND OTHER HEALTH CARE INSTITUTIONS

As provided in Section 663-1.7, HRS, the board shall review all adverse peer review decisions as decided by and reported by the medical societies, hospitals and other health care institutions. Failure to notify the board concerning these adverse decisions may be punishable by a fine not to exceed \$100. (In this section, the confidentiality of reports, use of information, etc. needs to be spelled out.)

ADD new Section 453-C—DISCIPLINARY ACTIONS: The Board may use any or all of the following methods of disciplinary action:

1. Suspend judgment
2. place on probation
3. suspend license
4. revoke license
5. place limitations on license
6. take other action including assessment of costs of disciplinary proceedings
7. temporarily suspend license without hearing if there is immediate danger to public
8. require further training or education as well as proof of competency to the satisfaction of the board.

ADD new Section 453-D OTHER INVESTIGATOR FUNCTIONS OF THE BOARD.

1. The board can call for specialty consultants whenever necessary from a list of nominees submitted by the specialty societies.
2. The board on its own can investigate any evidence which appears re incompetence
3. Any person can report to the board with immunity from civil action.
4. The board can order a mental, physical, or medical competency examination
5. Board can request help from medical association for conducting such examination
6. When person becomes licensed, implied consent is given for such examination as well as waiver to admissibility of information derived from exam.

MALPRACTICE INSURANCE, AD HOC COMMITTEE REPORT ON JUA PLAN, LEGISLATION, AND MUTUAL INSURANCE COMPANY

HOUSE ACTION: Filed

The Board of Directors of the Joint Underwriting Association has been engaged in the development of operating procedures and rules and regulations. We hope it never has to be activated.

Generally, the matters of the technical application of insurance principles involving such things as commissions, cost offsets, the administration, rate determinations, etc., have been the province of the insurance industry and the Insurance Commissioner. The representatives from the Medical Association have been involved with underwriting standards, provision for those that are uninsurable, professional discipline, etc.

The first hearing on the regulations will be held on October 31, 1975.

Legislative efforts are being directed toward the development of an omnibus bill relating to a number of different areas. The bill so far has been developing along the lines of an administrative measure to be submitted through the Department of Regulatory Agencies rather than through the

medical association. There are some advantages to this approach in that it involves the Hospital Association, the Bar Association, the Insurance Industry, the consumer public, as well as the physicians.

With the support of these varied segments of the community, the chance of getting favorable consideration from the legislature is enhanced.

In general the proposals being made are along the lines that were suggested to you much earlier. The draft of the actual bill is not yet available. It does, however, cover tort liability, claims adjustment, statute of limitations, arbitration, and professional discipline. Much remains to be done but things are moving along and we will have a good bill to submit to the legislature.

The concept of the Mutual Insurance Company is alive. A corporation has been formed through the joint efforts of the hospital association and HIMA. This corporation is engaged in working out arrangements for a feasibility study to determine whether or not we have a proper base for our own company and if we can achieve adequate market penetration to make such an effort effective. We should have the answers to these questions within the next thirty to sixty days.

There is no short, quick, and simple answer. A tremendous amount of research, study, and negotiation has to take place before things are to fall into proper perspective. Even if we get all of the proposed legislative corrections, we do not know how long it will take to arrive at a stable situation in which the insurance carriers can return to the market with any confidence.

ALBERT C.K. CHUN-HOON, M.D.

RESOLUTION NO. 3—Peer Review and Quality Care

HOUSE ACTION: Adopted

WHEREAS utilization review criteria for medicare and medicaid admission and continued inpatient care are modified many times unilaterally by HEW and their local representatives and,

WHEREAS fiscal intermediaries and local government agencies try continually to influence the development of these criteria and,

WHEREAS this influence by non-practicing physicians and laymen on criteria development is an attempt to control to fit their work requirements, and

WHEREAS so much of their work is surveillance, utilization control, and fiscal control (pay/no-pay) and

WHEREAS government programs and fiscal intermediaries have relegated the delivery of service, and the quality of that service to a level secondary to their primary preoccupation—pay or no-pay—and,

WHEREAS peer review by physicians has always intended to maintain or improve quality of care through review and education, now therefore be it

RESOLVED, that physicians providing service for peer review with service, quality, and education as program goals should continue to provide this service without charge if they choose, and be it further

RESOLVED, that physicians who are carrying out utilization review, fiscal review, etc. for insurance companies, government, fiscal intermediaries and etc. with service, quality and education being secondary are to be encouraged to charge their usual and customary fee, and be it further

RESOLVED, that all review criteria developed through committees of the Hawaii Medical Association or component medical societies before being instituted must be approved by the HMA Council and/or the membership of the local county medical society.

GEORGE H. MILLS, M.D.

RESOLUTION NO. 6—Confidentiality

HOUSE ACTION: Adopted

WHEREAS, confidentiality of medical information is of paramount interest to patient and physician, so therefore be it

RESOLVED, that the Model State Act for *Confidentiality of Medical Information* prepared by the AMA be reviewed by the HMA Council and appropriate committees for anticipated submission to the Hawaii State Legislature in January 1976 or 1977.

GEORGE H. MILLS, M.D.

RESOLUTION NO. 9—The Disabled Physician

HOUSE ACTION: Adopted

WHEREAS, the medical profession has been criticized for knowingly allowing ill and incompetent physicians to continue to practice, and

WHEREAS, we physicians agree that it is our responsibility to maintain the practice of medicine on the highest level, so therefore be it

RESOLVED, that the House of Delegates request the HMA Council and staff to review the model *Disabled Physician Act* designed by the legal and legislative resources of the AMA, and be it further

RESOLVED, that this model act, with recommended modifications, be presented to this House in 1976 as possible legislation for the 1977 State Legislature.

GEORGE H. MILLS, M.D.

RESOLUTION NO. 10—Medical Discipline Review

HOUSE ACTION: Adopted

WHEREAS, there has been much recent concern regarding the degree to which efficient discipline is maintained among medical practitioners in the interest of the public and the medical profession, and

WHEREAS, it is most important that the medical profession examine the adequacy of disciplinary rules, laws and procedures as applied to medical practice and licensure and medical society membership every ten to fifteen years, and

WHEREAS, this review can be initiated by examining current standards, procedures and rules of medical societies and boards that deal with professional discipline and to evaluate the adequacy of the existing system of medical discipline within the perspective of the practical, ethical and legal considerations; and

WHEREAS, this review can be augmented by evaluating existing state laws and medical licensure board regulations governing medical discipline; the effectiveness of such laws and regulations; and

WHEREAS, this review can be further augmented by studying the extent to which discipline is maintained by medical staff in government and privately owned hospitals throughout the state; and

WHEREAS, determining after the study if changes are necessary to improve the overall mechanism of equitable medical discipline in the interest of the public and the profession; and

WHEREAS, to recommend and draft, if necessary, based on results of thorough studies and investigation new legislation or amendments to existing legislation or to recommend new procedures for the association so that the quality of patient care may be improved by maintaining adequate standards of medical discipline, therefore be it

RESOLVED, that this House of Delegates request of the Council of the HMA to review the issue of medical discipline in Hawaii over the next year and report their findings to the 1976 House of Delegates of this association.

GEORGE H. MILLS, M.D.

RESOLUTION NO. 14—Section 453-5, Medical Practice Act, Suggested Changes In

HOUSE ACTION: Not Adopted

WHEREAS the trend is to include so-called consumers on all boards and commissions of government that deal with the public, and

The Dual Definition of Total Disability

by

MUTUAL BENEFIT LIFE

Here's Mutual Benefit's New Dual Definition of Total Disability due to injury or illness

1

EITHER you are unable to engage in your former occupation.

2

OR your monthly earned income has been reduced to one-fourth or less of your average monthly earned income for the twelve month period before total disability begins.

THE MUTUAL BENEFIT DUAL DEFINITION . . .

recognizes that professionals and executives, when disabled, have special needs not common to people in most other occupations. *Under the first part of this definition* you are considered totally disabled during the entire benefit period if you are unable, through sickness or injury, to engage in your own occupation, even if you could engage in another occupation. This definition recognizes and protects the considerable investment of time and money you have made in becoming highly skilled at your special line of work.

The second part of The Dual Definition considers professionals and executives to be totally disabled even if they continue to perform limited activities in their own occupation while they are disabled. Under this definition (if disabled through sickness or injury) you can collect full disability benefits for as long as your limited activities produce no more

than 25% of your previous income. This recognizes that professionals and executives generally have a drive to keep working even though they are disabled from carrying on full-time activities.

Under most conventional coverages neither of these special needs is recognized. Protection in one's own occupation, when provided, is often for a period less than the full benefit period. And coverage while performing limited activities, if available as a "partial disability" benefit, usually pays only one-half the full benefit and for only six months or less.

Under Mutual Benefit's Dual Definition, you will be considered totally disabled in *either* of the circumstances described in 1 or 2 above and will receive full benefits for the full benefit period. These more liberal benefits are available only for certain occupations.



Significant Features of the Professional Income Policy (H173)

Noncancelable and Guaranteed Continuable to Age 65

Only the timely payment of premiums is necessary to keep the policy in force until you become age 65. Thereafter, if you remain employed, the coverage is conditionally continuable to age 70 with maximum benefit periods of 24 months for accident and sickness.

The premiums to age 65 are guaranteed.

While your policy remains in force and regardless of your future health or the number of disabilities which may occur, no restrictive riders or endorsements may be placed on it after it is issued.

Dual Definition of Disability

Mutual Benefit's Professional Income Policy pays benefits when you are totally disabled by sickness or injury:

1. If you are unable to engage in your former occupation
or
2. If your disability reduces your income to 25% or less of what it was before disability (even if you *can* engage in your former occupation).

Presumptive Total Disability

You will be considered to be totally disabled if you have sustained the total and irrecoverable loss of speech or hearing or use of two limbs, or while you are deprived of your sight, even if you can still engage in your former occupation.

Waiver of Premium

For as long as you are disabled you don't have to pay premiums but the Company keeps the policy in force—starting with the day your benefits begin.

Recurrent Disability

If you recover, then become totally disabled again from a different cause, or from the same cause if you were able to engage in your former occupation for at least six months, your disability is considered a new disability.

This is an outline of coverage providing periodic benefit payments to help replace income when you are unable to work as a result of sickness or injury. ***It is not a contract.*** There are variations in Military Service and Pregnancy features in several states. Full details of your coverage are contained in policy form H173, as approved in your state.

If not, it is considered a continuation of the previous disability and the payments under the original benefit period, if any remain, are resumed immediately, without a new elimination period.

Dividends . . .

may serve to reduce your costs at a future date. The policy is participating and dividends must not be considered a guarantee, promise or estimate as to the future. The 1974 dividend scale provides for a dividend equal to 10% of the ultimate premium beginning at the end of the third policy year. This is equal to the increase in the guaranteed premium.

Military Service

Coverage terminates during military service. However, if you are discharged within 5 years from the time you enter military service, you have a guaranteed right to resume your coverage at the same premiums, within ninety days following discharge. Injuries sustained after the date of reinstatement and sickness manifested 10 days or more after the reinstatement date will be covered.

"First Manifest" Clause

The policy does not cover any condition which is evident before the policy issue date. It does, however, cover a latent condition existing before the issue date but whose first symptoms appear after the policy is in force.

10-day Free Look

If not fully satisfied, you can return your policy within 10 days for a full refund of any premiums paid.

Coverage Is Worldwide

There are no geographical limitations.

Pregnancy

Pregnancy and incidental complications are exceptions to coverage.

NOW!

We are offering a full line of noncancelable and guaranteed continuable— to age 65—individual disability income contracts . . .

- innovative policy provisions
- high issue and participation limits
- flexible for programming and business insurance situations

For Full Information ~ And For A
Complimentary Audit & Review
Of Your Disability Income Program

Call 531-4102
Or Write

E. G. "Kris" Brenno, CLU
Financial Advisory Clinic of Hawaii
P. O. Box 336
Honolulu, Hawaii 96809

General Agent for
MUTUAL BENEFIT LIFE
A name to remember.

WHEREAS the HMA Council went along with the recommendation of the Sub-committee of the Ad Hoc committee on Medical Malpractice Insurance, that one each from the legal and ecclesiastical professions be appointed to the board of medical examiners of the State under paragraph (2), and

WHEREAS such limitation of choice might exclude a highly qualified citizen who is not a lawyer nor a minister, now, therefore, be it

RESOLVED, that proposed language in recommendation (2) read: TWO ADDITIONAL MEMBERS OF THE BOARD SHALL BE APPOINTED TO REPRESENT THE LAY COMMUNITY.

J.I.F. REPPUN, M.D.

RESOLUTION NO. 15—Section 453-8, Medical Practice Act, Suggested Changes In

HOUSE ACTION: Not Adopted

WHEREAS the changing practice of medicine countenances "outreach" programs and the like, including intensive solicitation and enrollment by insurance carriers and by the government, of citizens who are urged to join a medical plan, now, therefore, be it

RESOLVED, that paragraph (2) as originally worded, as well as (2) as proposed change by the HMA Council and its committees, be deleted entirely.

J.I.F. REPPUN, M.D.

RESOLUTION NO. 16—Federal Umbrella over Malpractice Insurance

HOUSE ACTION: Not Adopted

WHEREAS HR 6100, known as the Hastings Bill, appears to be well thought out as presented in the United States Congress and probably to be further refined, and

WHEREAS the principle of "insurance" is based on a broad and extensive participation by a large number of subscribers, and

WHEREAS HR 6100 has the intent of providing this base to cover claims settlements above and beyond the maximum awards, i.e. those that would be catastrophic to both physician and insurance carrier, now, therefore, be it

RESOLVED, that the HMA endorse the concept as proposed in the Congress, and be it further

RESOLVED, that the HMA urge enactment of this bill into law.

J.I.F. REPPUN, M.D.

PROPOSAL FOR ANESTHESIA PEER REVIEW:

HOUSE ACTION: Adopted with the recommendation that a system for anesthesia review be established as a subcommittee of the HMA Peer Review Committee.

Consideration:

The increasing responsibility of anesthesiologists for financial liability attendant with untoward results of anesthetic practice be monitored for standards of care. Monitoring of standards of practice is best accomplished within the hospital setting where the subtle effects of various treatments on patient response can be identified first hand. These effects may result in a morbidity not identifiable in a final discharge diagnosis, the mechanism whereby chart review is usually accomplished. Never-the-less, a statewide monitoring of major morbidity and especially mortality, where the anesthesiologist or nurse anesthetist is responsible or where their actions are contributory appears to be a minimal requirement. This requirement is engendered by our responsibility to patient welfare, by the necessity of being publicly accountable, and by the increasing insurance premiums, amount of litigation, and awards concerning anesthetic practices.

Proposal:

The development of a uniform statewide review mechanism for anesthetic practices which provides a mechanism for review at the individual hospital level of a wide range of anesthetic related problems, and which contains the mechanism for referral of more major complications to a state-level committee of the HMA.

A. Hospital review:

1. Periodic review of the practice of each anesthesiologist and nurse anesthetist in every hospital in the state of Hawaii.

a. Anesthesia Review Committee appointed within the department of anesthesia or the medical advisory committee if a department of anesthesia does not exist or is not large enough to objectively review the anesthetic practice of that department.

b. Medical record tabulation of complications for the department of anesthesia and its individual members to establish a "track record" . . .

2. Medical record review of incidence of specific complications through a uniform reporting system.

a. Operating room log of cardiac arrests and other untoward events related to anesthesia, e.g. aspiration of gastric contents, severe or prolonged hypotension, broken teeth, difficult intubation resulting in cancellation of surgery or injury to patient, convulsion, major transfusion reaction, etc.

b. Recovery room log of untoward events related to anesthesia, e.g. respiratory failure secondary to the effects of muscle relaxants, severe or prolonged hypotension, pulmonary edema, central cholinergic crisis, etc.

c. Medical record review of postoperative complications related to anesthesia (Ref H-ICDA 2nd ed for medical record coding)

1. Code 931 Surgical and medical complications and misadventures.

2. Specific diagnosis to be reviewed:

410.0 Myocardial infarction

415.8 Cardiac arrest

427.9 Congestive heart failure

519.0 Atelectasis

573.5 Hepatic failure

585.9 Renal failure

796.3 Respiratory failure

997.0 Post spinal headache

998.0 Postoperative shock

998.1 Postoperative hemorrhage

999.4 Anaphylactic shock

999.7 Complications due to extracorporeal circulation

3. Others referred by anesthesiologists, anesthesiologists, or other medical activity review committees.

d. Attribution of cases reviewed by the peer review committee

1. Anesthesia responsible

2. Anesthesia contributory

3. Anesthesia unrelated

e. Disposition of cases reviewed by the peer review committee

1. Refer to anesthesia department for discussion

2. Refer to MD credentials committee for corrective or educational action.

3. Refer to other departments

4. Refer to HMA Anesthesia peer review committee.

B. HMA Anesthesia peer review committee:

Reviews all cases referred from individual hospital anesthesia review committees for possible further referral to appropriate committees of the HMA.

ARTHUR Y. SPRAGUE, M.D.

MISCELLANEOUS BUSINESS REFERENCE COMMITTEE

BUREAU OF RESEARCH AND PLANNING

HOUSE ACTION: Adopted

The Bureau of Research and Planning was asked by the last House of Delegates to compile a handbook for the Association outlining the various policies and position papers on which the HMA has developed a stand. Copies of similar handbooks were circulated but several attempts to constitute a quorum for a meeting were not successful. We have not abandoned the proposal and recommend that the committee continue to push for completion of the handbook by 1976.

WILLIAM E. IACONETT, M.D.

COMMISSION ON INTERNAL AFFAIRS

HOUSE ACTION: Acopted

Convention Committee

The Convention Committee was charged with the responsibility of setting up a meeting for the House of Delegates and the various events taking place during the annual meeting of this year. Since there was no scientific session, the emphasis was placed on the other events of the meeting—sports activities and the annual banquet.

The AMA will meet in its clinical session in Honolulu and the Convention Committee is arranging a dinner with the California delegation.

The Auxiliary to the HMA

This active organization is helping plan the annual banquet for the HMA and also cooperating with the AMA Convention Committee in hosting the various State delegations.

The Bylaws Committee

The Bylaws Committee did not meet this year.

Recommendation:

That the dates for the 1976 Annual Meeting of the HMA and its location be determined by the HMA Council.

R. VARIAN SLOAN, M.D.

COMMISSION ON LEGISLATION

HOUSE ACTION: Adopted with the exception of Recommendation No. 2 of the Pharmacy Committee which was referred back to the committee for re-evaluation and suggestion of an alternative proposal.

Legislative Committee

As expected the 1975 Session of the Eighth State Legislature was very active in bills and resolutions relating to health and the medical profession. Since the House of Delegates of the Association did not mandate any major legislative proposal, the committee did not request the Council of the Association to retain a legislative counsel during the 1975 session of the State Legislature.

The Legislative Committee working closely and in concert with the officers and the many committees and commissions of the Association took positions and presented testimony on most of the significant legislative proposals which would affect the medical profession. Living up to our expectations our legislative secretary, Mrs. Becky Kendro, kept the committee apprised of the rapidly changing scene in the State Legislature. The active participation of the staff, Mr. Thomas Rice, our legal counsel, and many members of the Association in legislative matters in which particular expertise was necessary is gratefully acknowledged.

The 1975 session of the Eighth State Legislature was a budget session. Funds for the Medical School at the University of Hawaii and a statewide School Health Program were included in the budget. Funds were especially noted for free immunization of children by the Department of Health without regard to means. In addition, money was appropriated for the Breast Cancer Project of the Cancer Society and the Pacific Health Research Institute.

The following are some of the major measures which passed the legislature and were supported by the Association:

- (1) HB 431 will provide for the assignment of a third party payment to Medicaid for those receiving public assistance for medical care.

- (2) HB 518 provides immunity for peer review committees and allows them to communicate with governmental agencies such as the Board of Medical Examiners and the DSSH Department of Social Services and Housing.
- (3) HB 619 allows treatment of minors with venereal disease and places notification to parents of minors found to be afflicted within the discretion of the physician if the minor is forewarned of this discretion by the physician. Treatment is to include counseling. (Note: This is the only amendment to the minor's consent law which survived debate. Efforts for the inclusion of family planning, pregnancy and substance abuse into this provision of the minor consent law will be continued.)
- (4) HB 946 includes a definition of child abuse which conforms to federal regulations.
- (5) HB 990 places the administration of the state substance abuse program in the Department of Health with the State Advisory Commission on Drug Abuse (created several years ago) to serve as an advisory committee to the Department of Health.
- (6) HB 1876 provides for a pooling of joint underwriting arrangement to assure availability of malpractice insurance coverage. (Insurance Commissioner can implement only if malpractice insurance becomes unavailable in Hawaii).
- (7) SB 1628 provides for coordination of services for developmentally disabled and creates 25 member Council under the Office of the Governor.
- (8) HCR 119 requests that the budget submitted by the Governor include Medicaid payments for health providers their customary fees to the extent that federal rules permit. (Note: SB 1046 providing for usual and customary fees up to the maximum which federal rules permit the DSSH to pay dentists was enacted. Although the next session is not a budget session we will request an amendment to include medical care).
- (9) HCR 122 requests the Department of Health (with HMA assistance) to develop necessary legislation and a plan of action for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for all children.
- (10) SR 203 resolves that no legislation be enacted at this time to require continuing education as a requirement for relicensure of physicians and other licensed health professionals. The resolution calls for the development of programs by the professional organizations including criteria for judging programs, monitoring attendance, and certifying those who do attend. The Department of Regulatory Agencies is requested to provide support to organizations of health professionals to assist in the collection of data "for the future formulation of legislation on continuing education and relicensure of health professionals" and that data collection begin no later than July 1, 1976.

Some of the bills which have been opposed by the Association and filed in various committees of the legislature and which may become alive in the next session are those relating to no fault malpractice insurance, mandatory reporting of cancer, generic drug substitution, release of medical records to patients, establishment of health facilities authority and inclusion of two consumers on all boards and commissions (which would include the Board of Medical Examiners).

Since the next session of the Legislature is not a budget session, the legislators will devote a great deal of time to non-fiscal matters. Among these will undoubtedly be amendments to the laws relating to medical malpractice. For this reason, the need to retain an attorney as legislative counsel from within the party in power appears mandatory. A full report on the issues involved was compiled and mailed to all members of the Association by the Ad Hoc Committee on Medical Malpractice.

Budget Request:

Legislative Counsel	\$7,500.00
Today's Health	300.00
Miscellaneous	400.00
	<hr/>
	\$8,200.00

Recommendations:

- (1) That the budget of the Legislative Committee be approved and the services of Mr. Kazuhisa Abe be retained as our legislative counsel.
- (2) That the efficient services of our legislative secretary, Mrs. Becky Kendro, be acknowledged.

GEORGE GOTO, M.D.

Pharmacy Committee

Members of the Pharmacy Committee were actively involved during the past year in presenting testimony to the Legislature opposing the repeal of Hawaii's anti-substitution laws or any liberalization of the generic substitution law. Meetings were held with representatives of the Food and Drug Branch of the Department of Health, Hawaii Pharmaceutical Association and the Hawaii Nurses Association. An educational bulletin was prepared for the HAWAII MEDICAL JOURNAL asking physician compliance with existing prescribing regulations. The committee also developed proposed amendments to current state laws which would allow physicians to dispense scheduled substances from hospital pharmacy stock in emergency situations when a hospital pharmacist is not available.

Recommendations:

- (1) That approval be given for the proposed amendment to the Public Health Regulations for dispensing of controlled substances in the hospital emergency room as printed below (see Appendix A).
- (2) That the HMA support a proposal of the Department of Health to require physicians to document the fact that the patient is currently not using a scheduled substance from another doctor.

VINCENT S. AOKI, M.D.

Appendix A-
To be added as Item H, Section 5, Prescriptions, Public Health Regulations, Department of Health, State of Hawaii, Chapter 45 (Controlled Substances)

- H. Exception—Dispensing of Controlled Substances in the Hospital Emergency Room
 - I. In the event of an emergency, a hospital may authorize a licensed physician registered with the Drug Enforcement Agency (DEA) to prescribe and dispense controlled substances from the hospital drug supplies provided that:
 - (a) In the Act of Dispensing, all requirements of Part 306; Prescriptions, of the Federal Controlled Substance Act (PL 91-513) be followed;
 - (b) The amount dispensed does not exceed the amount required for the emergency;
 - (c) For the purpose of this section, an emergency shall mean a situation where a quantity of a controlled substance must be dispensed to a person who does not have an alternative source for such substances reasonably available to him.

COMMISSION ON INTERPROFESSIONAL AND PUBLIC AFFAIRS

HOUSE ACTION: Adopted as follows

Once again in conjunction with the Hawaii Newspaper Agency represented by Mrs. Barbara Edwards the Public Affairs committee sponsored several more public forums at Farrington High School auditorium, Wahiawa cafetorium and at the University of Hawaii.

The emergency medical programs were highly successful. We look forward to another year of these forums. We are bogged down on getting a questionnaire out to our membership regarding their feelings on vital issues. We are trying to get this together and this will be a priority project for '75-'76.

The recipient for the A.H. Robins Physician of the Year Award was selected and will be announced at the Annual Banquet. The Hawaiian Science and Engineering Fair was supported by the Association and our contribution was well received.

The most exciting work this year has been with the conceptualization of Hawaii Audio-Visual Medical Educational Depository (Hav-Med) known on the Mainland as Tel-Med, which is a telephone call-in taped message on health.

The Inter-Professional Relations Committee met approximately eight times out of the year and towards the end of the sessions was finding difficulty in establishing problems to address.

The Medico-Legal Symposium, in the past an annual affair, was replaced by an address by the Honorable Daniel K. Inouye on S. 215 relating to no-fault medical injury compensation.

The Medical-Legal I.Q. has apparently been elevated to the point where fewer problems needed to be addressed by this committee.

The Intra-Professional Liaison Committee has established a liaison group which has become autonomous and having accomplished this job, I would recommend this committee be disbanded and instead an intra-professional liaison be acquainted.

The Health Facilities Committee held two meetings, the first to discuss the functions of the committee and the second to study Act 209 (Comprehensive Health Planning Act) and certificate of need. The problems of Act 97 hospitals (county state hospitals) were not discussed this year pending experience with the new state administration and new director of health. In reviewing the function of the committee, it was recommended and the HMA Council concurred, that the committee need not attempt to study the distribution and availability of health facilities. The committee also recommended that HMA not pursue any legislative changes in Act 209 at this time regarding definitions of "provider" and "consumer." The committee continues to be concerned about the low ratio of physician members on various boards, commissions, review panels, etc. which are involved in decision-making directly affecting the medical profession. The committee will continue to strive for greater input in the coming year.

Recommendations:

- (1) The Interprofessional Relations Committee recommends that the committee continue to function as an interface between the medical and legal professions and that the project of personal contacts (as outlined in the committee report) with physicians or attorneys who precipitate complaints be activated by the Interprofessional Relations Committee and that a file be kept of the resolutions of the problems, including reference to specific issues, interpretations, and actions.

Budget Request:

News Media Awards	\$ 800.00
Hawaiian Science Fair	200.00
Physician Questionnaire	300.00
Tel-Med	500.00
	<hr/> \$1800.00

ROWLIN L. LICHTER, M.D.

PRESIDENT'S REPORT

HOUSE ACTION: Filed

The HMA needs you! It needs your participation, your understanding, and your support. The past year has more clearly demonstrated these needs. Unfortunately, the factor of communication, necessary to fulfill these needs, is almost impossible to achieve with perfection and satisfaction to all concerned. The recent visit to all four county medical societies by your officers and staff provided one of the methods of achieving the goal of communication to achieve understanding and trust.

One of the most critical problems the HMA faced and still needs to urgently resolve is that of the malpractice issue. Your diligent ad hoc committee on this issue has recommended, with Council's approval, many major changes that will have a significant bearing on each and every member. The malpractice issue appears to be best resolved by legislative action which changes the existing tort system to an arbitration system, which changes the method of compensation, with monetary limitations, to the lawyer and to the plaintiff, which changes certain statutes that might make insurance premiums more predictable, and, hopefully, more manageable, and which hopefully will make the system more efficient where damages are justified. It appears that our medical profession must also re-assess its role in the malpractice problem although we as a profession may justifiably feel that we are, for the most part, credible and accountable. This, unfortunately, is not the view of the entire community in which we live. I feel that some physicians are much too paranoid about this concern; but, yet, one can always improve and seek changes that may benefit our profession. Your ad hoc committee and your Council have made some momentous decisions:

- (1) It has established that all peer review activities resulting in an adverse decision against a physician relative to his competence or his conduct will be transmitted to the Board of Medical Examiners;
- (2) It has recommended that legislation be enacted to institute mandatory continuing medical education; and
- (3) It has recommended that lay representatives from the legal and the ecclesiastical communities be represented on the Board of Medical Examiners.

I am sure that this current HMA policy will be met by some degree of criticism within our profession, but I am equally sure that this commitment will make us a rare profession that can be said to be credible and accountable.

The malpractice crisis should also, hopefully, teach the members of HMA that a unified, objectively deliberated direction can be achieved if we in organized medicine work together. This need for unity can be applied to many other problems that face HMA, such as the DSSH reimbursement issue, the development and reaction to federal programs, and the ever-increasing desire of non-medical organizations to attempt to interfere in the practice of medicine. We need to listen, we need to expend time in doing non-medical homework and, thusly, make decisions, or changes if necessary, that will represent a strong, single voice for our membership. We must fight when we are right!

The problem of unity within organized medicine continues to be rightfully questioned. It is abundantly clear that the constraints upon the medical profession require us to unite at all levels, including the national level. It is also abundantly clear that no one organization will, at all times, represent the views of all of its membership. And lastly, if we in Hawaii, abandon the AMA, we will exist as parasites to this national organization since we will not be fulfilling our economic and moral obligations. We should not criticize without complete understanding, but rather, try to improve the mechanism to achieve a stronger organization.

The problem of the future HMA home has been deliberated by multiple members of our association on the site committees spanning many years. The results have been unfruitful, largely because of any overt financial commitment by HMA members that would make the objectives of the site committees attainable. Hopefully, the recommendations of an ad hoc Committee on Future Site Recommendations to be presented to this House of Delegates will resolve the commitment or lack of commitment of our organization relative to the needs of our "home."

The Publications Committee and the editorial staff of the HAWAII MEDICAL JOURNAL are to be commended for improving the utility of the Journal and, more importantly, for achieving a sound financial basis for the Journal's operation. Hopefully, this vehicle will be a key method of communication to our membership.

Continuing medical education must remain a critical priority of our organization. Much has been accomplished, but

much more needs to be done. It would appear that the greatest problem is to decipher the method of continuing medical education that will best assure our ever-longing quest of delivering quality medical care.

In closing, it appears that HMA has met many of its problems and, hopefully, has resolved these problems in the most honest and effective manner. If any benefits of last year's activities have been obtained, then appropriate appreciation must be given to the hardworking commissions, committee chairmen, and, most importantly to the Council members who diligently attended the monthly Council meetings. Special appreciation is extended to the administrative and secretarial staff. I leave with confidence that your future officers will direct the HMA for the betterment of our medical profession.

Recommendations:

I have no recommendations, but I feel that serious consideration should be given to the concept that our bylaws should be revised in such a manner that the President may remain in office for at least two years if this prolonged servitude can be tolerated by that president and by the organization.

WINFRED Y. LEE, M.D.

SECRETARY

HOUSE ACTION: Filed

The total active membership of the Association as of December 31, 1974 was 946, an increase of 37 compared to December 31, 1973 which was 909. The special members numbered 35, a decrease of five from the previous year. Of the 946 active members, 110 were granted a dues waiver, an increase of 13 over the previous year.

Ten members died since the last annual meeting: F.J. Pinkerton, Albert Shimamura, Frederick S.F. Lee, E.W. Haertig, John Bell, Sanford Katsuki, Maria Faus, Hoichiro Uchiyama, Y.S. Seto and K. Hosoi.

Unaffiliated physicians were reported by the counties as follows: Hawaii 8, Maui 5, Honolulu 372, and Kauai (unreported).

By counties, the active membership was made up as follows as of December 31, 1974:

County	Active Dues Paying	Active Dues Waived	Total
Hawaii	59	15	74
Honolulu	684	86	770
Maui	61	5	66
Kauai	32	4	36
	836	110	946

As of September 30, 1975, the active membership has increased to a total of 978 members.

Since the last annual meeting, there have been nine Council meetings that were held in 1975 as follows: January 10, February 14, March 14, April 18, May 9, July 11, August 7, August 29, and September 26. The HMA Executive Board also met on 12 occasions and actions taken at these meetings were approved by the Council.

At the January 10, 1975 meeting, officers of the Community Research Bureau were elected: B. Allen Richardson, President; Theodore T. Tomita, Vice President; O.D. Pinkerton, Secretary; and Grover H. Batten, Treasurer. Also elected were trustees for the Hawaii Foundation for Medical Care: Henry Yokoyama, Peter Kim, and Sakae Uehara. Dr. William Iaconetti was asked to serve as chairman of the Bureau of Research and Planning and members were elected as follows: William Dang, Richard Omura, Fred I. Gilbert, Wilbur Lummis, and Verne Waite. Drs. Marcelino Avecilla, Albert Chun-Hoon, Elmer Johnson, Richard Omura, and John Edwards were elected to the Finance Committee for one-year terms. Dr. Grover H. Batten was nominated to serve as the HMA representative on the Cancer Commission and was appointed by the President to serve as Chairman of the commission.

Representatives from the Physician's, Dentist's, and Optometrist's Action Group summarized the activities of the

group regarding services to Medicaid patients and fees for these services. The Council reaffirmed its position of August 26, 1974 supporting the request of the Action Group for action to permit a revision of fees and increased availability of services for Medicaid patients. Professional liability insurance problems were discussed at length and it was recommended that an immediate meeting be scheduled with Argonaut Insurance Company representatives. Council directed that a letter be written to the Director of Health asking that the school health services program in the Department of Health be elevated to a division level rather than as a branch of Child Health Services. Support was given to the American Cancer Society's request to the State Legislature for supplemental funds to meet unbudgeted needs in the Pacific Health Research Institute Breast Cancer Detection Project. Support was also given for the action of the Executive Board of the Cancer Center of Hawaii in applying for a planning grant to fund the cancer control program. Approval was given for testimony prepared for the hearing on the rules and regulations to Act 209, Comprehensive Health Planning.

Receipt of a new Workmen's Compensation Fee Schedule was announced. The schedule adopted the five-digit coding of the 1970 Hawaii RVS, removed the differential fee for specialists, and provided an adjustment in the level of the fee. Testimony for the January 14 hearing on the DSS Fee schedule was reviewed and approved. It was reported that three ambulances were leased to the State and one to the City and County of Honolulu under the HMA's EMS program. The Executive Board was directed to review the contract between the Research Corporation and the HMA relative to the Hawaii Tumor Registry. Council also reaffirmed their original position expressed in 1959 that HMA owns the Registry and further recommended that the HMA President select the two SEER representatives who will represent the Registry at meetings of the SEER Group (Surveillance, Epidemiology, and End Results Group of National Cancer Institute).

Progress reports were presented regarding PSRO and the continued efforts of the Site Committee to seek new headquarters offices. Three HMA representatives were designated to attend a January 23-24 meeting in San Francisco regarding PL 93-641 (the National Health Planning and Resources Development Act of 1974). In the President's Message, he announced he had met with committee chairmen and commissioners to discuss goals and objectives for 1975. He noted that he would especially like to meet with neighbor island societies. Travel to the U.S. Pharmacopoeial Convention was approved for Dr. Daniel Palmer, HMA's delegate.

At the February 14 meeting, it was reported that a meeting on medical malpractice legislation had been held with representatives of Argonaut Insurance Company, the Board of Underwriters, the Department of Regulatory Agencies, and presidents and peer review activity chairmen of all county medical societies. It was agreed that certain stop-gap legislation should be introduced immediately, such as a pooling plan for all casualty carriers, some form of pre-trial arbitration and certain revisions to the committee immunity law.

The 1975 House of Delegates meeting and banquet were scheduled for October 24-26. It was voted to reaffirm the position of the 1973 House of Delegates recommending that a current assessment of needs and job opportunities be made before embarking on a training program for physician's assistants. At the DSS public hearing on January 14, in view of the overwhelming opposition to the proposal, the administrator of the medical care division agreed to discuss the schedule further with the Department. The Economic Evaluation and Adjustment Committee met with the Physician's, Dentist's and Optometrist's Action group and appeared before several committees of the Legislature. After reviewing the testimony prepared on the subject of cancer control, it was recommended that an article be prepared for inclusion in the Hawaii Medical Journal on this subject. A report on the San Francisco meeting on the subject of PL 93-641 was presented. Council directed that a letter be written to the

Governor expressing the willingness of the HMA to participate and cooperate with the liaison officer for the implementation of PL 93-641. Endorsement was given for the Home Care Cancer Service Program of St. Francis Hospital.

At the March 14 meeting, approval was given for the publication of an educational bulletin regarding dispensing drugs and labelling requirements as recommended by the Pharmacy Committee. The functions of the Professional Liability Committee were reviewed in detail including the manner in which the committee processes matters referred to it. The functions of the committee as set forth in 1971 were reaffirmed. HMA's legal counsel recommended that all county medical societies submit their bylaws for review to assure that procedures for due process in any disciplinary review are present. It was also recommended that the State Peer Review Committee functions be expanded to include the right to hear cases referred to it whenever decisions from a subcommittee are appealed. HMA was asked to participate on a committee which will review the entire malpractice insurance situation in the State including legislative proposals for 1976. It was reported that the public forums co-sponsored by the HMA with the Hawaii Newspaper Agency continue to draw large crowds. The universal emergency telephone number 911, was implemented in cooperation with the EMS program. It was also announced that approval was given for the continuing standards of performance for the MICTs. Drs. Herbert Chinn and William Dang were appointed to the Governor's Ad Hoc Committee on Area Designation for PL 93-641 which is investigating various possibilities for area designations for the state. It was voted to recommend that one Health Service Area be designated for the State of Hawaii. A progress report on the accreditation of various hospital and institutional continuing medical education programs was presented. It was noted that a calendar of CME is included in each issue of the HM Journal. A seminar designed to help hospitals develop accredited CME programs is being developed with funds received from the Regional Medical Program. The HMA President met several times with the Cancer Commission and asked that goals and objectives for the year be outlined. Travel funds for the Hawaii Tumor Registry staff were cut back considerably. The Site Committee reported to be seriously considering a proposal to lease temporary office space while pursuing a more permanent location for the HMA-HCMS administrative offices. Nomination materials were mailed to all PSRO members for election of the PSRO Board of Directors. Appointees to various community committees and agencies were announced as follows: Dr. Elisabeth Anderson, Dr. Grover Batten, Jon Won and Tom Thorson to Health and Community Services Council; Jon Won and Dr. William Dang to Waianae Comprehensive Health Center, Dr. J.I.F. Reppun to the Department of Health Patient Education Program; Dr. Thomas Lau, Blood Cell Advisory Committee at St. Francis; Drs. Ann Catts and Fred I. Gilbert, Department of Health Laboratory Advisory Committee. A proposal from Elson-Alexandre Company of Los Angeles to publish a new roster was reviewed in detail and it was voted to proceed with the proposal as outlined, separating the Bylaws from the Roster.

At the April 18 meeting, representatives from Chaney, Inc. presented a proposal for leased office space for the HMA-HCMS headquarters. This proposal was presented as an interim plan until a suitable long-term or permanent site could be obtained. A motion to accept the proposal of Chaney, Inc. failed to pass. The seminar on developing accredited CME programs in hospitals was scheduled for May 12 and 13. HMA's grant request for RMP funding of the Quality Assurance Program Development was reactivated. Dr. Sia reported the Legislature approved the statewide school health program to be implemented over a four-year period. The Health Manpower Committee was asked to report back to the Council on their assessment of need for physician's assistants. An ad hoc committee on medical malpractice insurance was formed and neighbor island counties were asked to submit their nominees for representation on the committee. A summary of legislative activity

was circulated. A request to return certain EMS contract funds to the City and County of Honolulu to complete the radio system and upgrade the Medicom System in Kahuku, Wahiawa and the airport area was approved. Dr. Dang reported that the ad hoc committee on PL 93-641 voted to recommend to the Governor that there be one health service area for the State. A contract between the RCUH, Cancer Center and HMA to continue the demographic contract with NCI was signed on April 1, 1975. Inasmuch as no travel funds were included in the contract, the Council voted to approve an appropriation up to \$5,000 for travel for Hawaii Tumor Registry business. A report on Auxiliary activities was presented by President Jackie Jones. She was asked to present the AMA-ERF check to the medical school at the University of Hawaii at the graduation ceremonies. The deadline for nominations to the PSRO Board was extended to April 30. Senator Daniel Inouye invited written testimony on Senate Bill 215 and other malpractice bills before Senator Kennedy's subcommittee on Health, Committee on Labor and Public Welfare. A letter to Governor Ariyoshi regarding services to Medicaid patients was circulated for review. Dr. William Dang and Mr. Tom Thorson were asked to attend the National Conference of State Legislatures in Washington, D.C. on May 8 and 9. The conference was devoted to medical malpractice issues. Dr. Alan Pavel was asked to attend a symposium on medico-legal problems given by the American Academy of Orthopedic Surgeons in Chicago. A resolution relating to compulsory enrollment in health insurance was submitted to the AMA Delegate and Alternate Delegate for their comments.

The treasurer reported at the May 9 Council meeting that the Finance Committee and Publications Committee had reviewed the finances for the HAWAII MEDICAL JOURNAL and that the Journal was within budget. Dr. Robert Worth asked for endorsement of the Pacific Health Research Institute proposal for a Hawaii Health Services Research Center. He also asked for a nominee from HMA to serve on the board of directors of the Research Center. His requests were referred to the HMA Executive Committee for further study and recommendation. Pre-registration for the CME Conference was excellent. It was also reported that HMA's request for RMP funding of a Quality Assurance Program was given low priority for funding. A report on the medico-legal conference attended by Dr. Pavel was reviewed. It was announced that the Ad Hoc Committee on Medical Malpractice will be chaired by Dr. Albert Chun-Hoon with members Drs. William Dang, John Lowrey, Alan Pavel, Fred Reppun, Chew Mung Lum, Ken McCollum, and Peter Kim (Hawaii representative to be added). The Auxiliary was asked to assist in the selection of a gift of appreciation for the retiring president of the AMA Auxiliary, Mrs. Betty Liljestrand. The Auxiliary noted their willingness to assist the Association in various activities. Support was given to the Alcohol Education Program scheduled for September 28 at the Ala Moana Hotel. Winners of the HMA awards for the 18th Hawaiian Science Fair were announced. The travel itinerary for Tumor Registry staff was reviewed. It was reported that Dr. Audrey Mertz has replaced Dr. Thomas Burch as the Department of Health representative to the Cancer Commission. It was announced that Dr. Benjamin Lambiote was appointed Medical Director for the Workmen's Compensation Division. After the previous Council meeting, representatives from Chaney, Inc. agreed to modify their proposal for office space for HMA-HCMS. The proposal as well as the costs relating to moving and the various rental agreements presently in effect were reviewed in detail. It was voted to disapprove the modification of the proposal offered and it was recommended that the Site Committee consider the expansion of the Mabel Smyth Building which was proposed several years ago. An AMA resolution relating to the status of Medical Officers in American Samoa and the Trust Territory of the Pacific with a view to affording them professional recognition and that consideration be given to their inclusion as PSRO members was supported. The Council also asked that the delegate consider voting in support of candidate Joe Boyle for the AMA Board.

Correspondence from the AMA indicated there was a considerable reduction in staff in an attempt to stabilize the AMA's financial situation. It was also noted that the editor of JAMA, Dr. Robert Moser (Maui), resigned from his position with the journal effective May 31.

At the July 11 meeting, a letter calling for the repeal of that portion of the bylaws requiring membership in the AMA was discussed. The letter was referred to the Bylaws Committee and will be circulated to the membership prior to the annual meeting. A representative from the AMA has been invited to discuss the role of the AMA and answer any questions. Dr. George Mills, AMA Delegate, reported on the activities at the AMA Convention. Council directed that the report of the Crippled Children Committee on the proposed plan for Health Services to the Developmentally Disabled be forwarded to the Director of Health. Dr. Robert Latta represented the HMA at a conference on alcoholism and submitted a written report. HMA nominees for the director of the newly created alcoholism and substance abuse division in the Department of Health were submitted to the Director. Nearly 100 persons attended the CME conference on May 12-13. Guidelines for medical malpractice legislation as recommended by the Ad Hoc Committee on Medical Malpractice were reviewed and approved in principle. The guidelines will be refined and distributed to the entire HMA membership. The possibility of a membership survey regarding medical malpractice experience was discussed and Council agreed that the information should be obtained in a strictly anonymous manner except for the identification of specialty classification. A letter to all members regarding the formation of a mutual insurance company for medical malpractice in cooperation with the Hospital Association of Hawaii was discussed in detail. Approval was given for the creation of a corporation appropriate for the creation and/or management of a mutual insurance company. The Peer Review Committee asked all county medical societies to submit copies of their bylaws and forwarded them to legal counsel. Hawaii County expressed some areas of particular concern to their society and asked that a delegation from the HMA meet with the county medical society in the near future. The Convention Committee presented their recommendations for a party for the California delegation during the AMA Clinical Session and authorization was given for an expenditure not to exceed \$1,800. The Public Affairs Committee is investigating a patient education program utilizing tape recorded health messages available by telephone and known as Tel-Med. The Tel-Med concept was supported and the committee was asked to investigate the feasibility of instituting Tel-Med, possibly utilizing the Physician's Exchange personnel for the program. The Community Health Care Committee reviewed the Waianae Coast Comprehensive Health Center request for a certificate of need to add a building to the outpatient facility. The Committee concluded that the existing buildings at the Center were adequate for current and anticipated needs and it was voted to forward the committee's recommendation to Comprehensive Health Planning. It was also voted to adopt the AMA's policy on community professional directories which states in part "that it is not unethical for a physician to list his name and practice in a directory for community use provided that such a listing be done on a non-discriminatory basis." A resolution regarding the use of HCG in the treatment of obesity was adopted as follows: "That the HMA adopt a strong policy in opposition to the use of human chorionic gonadotropin (HCG) in weight control programs and that the HMA take the lead in developing a public education program to warn the citizens about the potential dangers of such a weight control program." Staff was asked to consider the requirements for renovation and refurbishing of the present administrative offices and it was voted to authorize the expenditure of up to \$1,000 to retain Architect Ossipoff contingent upon the approval of the HCMS Board of Governors. Council agreed that 1,500 copies of the 1975 Roster should be ordered for distribution as follows: one free copy to all HMA members and new members and 20 copies for the Auxiliary; additional copies to be \$5.00 for HMA members

and \$10.00 for non-members.

At the August 7 meeting, the Legislative Committee was asked to submit their recommendation regarding a legislative counsel including budget requirements at the next Council meeting. The chairman of the EMS Executive Board recommended that all fiscal matters regarding the EMS Executive Board recommended that all fiscal matters regarding the EMS project be handled by the HMA Finance Committee noting that often the board is not aware of various fiscal matters as they relate to HMA policies. It was voted to appoint the fiscal officer, Mr. Tom Thorson, or his delegate as an ex-officio, non-voting, member of the EMS Board. It was further voted to refer the guidelines on HMA policies to the project director. Progress reports on the Advisory Committee on PL 93-641, Cancer Commission and PSRO were reviewed. A motion opposing a resolution regarding unified membership was tabled. A report on renovation was presented in detail and the concept of the changes proposed by the architect were approved although a motion to authorize an additional \$1,500 for further architectural studies failed to pass. A special committee was appointed to look into all possibilities and come up with some firm statistics and cost figures. The ad hoc committee on medical malpractice presented eleven policy statements on the subject of medical malpractice (included in the committee report to the House of Delegates). The report was sent to all members of the association. It was announced that the first board meeting of the corporation formed to explore the feasibility of developing a mutual insurance company would be held on August 12. Drs. Albert Chun-Hoon, C.M. Lum, William Dang, Winfred Lee, and Rod West plus Mr. Tom Thorson represent the HMA on the Board. The HMA Executive Committee reviewed the proposal of the Hawaii Health Service Research Center in detail and recommended that the project not be endorsed. A committee was formed to look into the feasibility of forming a subsidiary organization to be referred to as the Hawaii Professional Review Organization (HPRO). An ad hoc committee was appointed to prepare a leaflet on Medicare which will be made available to all HMA members for distribution to their Medicare patients. A resolution of authority for signatures on contracts, bids, or proposals was accepted.

At the August 29 meeting it was announced that funds are available through DHEW for agencies interested in conducting a study on the feasibility of developing a Health Service Agency. It was voted to apply for a grant. A proposed budget for the Tel-Med patient education program was submitted and approved and the Public Affairs Committee was asked to present a report as to any sponsorship at the next Council meeting. Progress reports were presented on the activities of the Ad Hoc Committee on Medical malpractice which is reviewing the Medical Practice Act with a view toward various legislative amendments. Reports were also presented on the activities of the Joint Underwriting Committee and the Board of the corporation studying the formation of a mutual insurance company. The Pharmacy Committee submitted their recommendation for an amendment to the Public Health Regulations of the Department of Health regarding dispensing of controlled substances in emergency rooms. Council asked that the Fee Survey Committee continue to pursue an investigation into the possibility of inequitable rates for participating and non-participating physicians in HMSA. Council voted to support a recommendation for repeal of the Free Ambulance Act as recommended by the project director of the EMS project. The Tumor Registry recently published a study on the patterns of cancer between 1960-1964 and 1968-1973. Dr. Henry Oyama was appointed chairman of the committee looking into the feasibility of forming HPRO (Hawaii Professional Review Organization). The Hospital Association of Hawaii and the HMA are considering the formation of a data collection corporation for anticipated data processing duties under PacPSRO. The role of the President's Assistant with regard to job responsibilities and term of office were discussed. It was voted to approve Dr. Grover Batten as Assistant to the President for three months.

The September 26 meeting was devoted primarily to discussions regarding the proposed budget for 1976. Council agreed with the recommendations of the Common Fund Executive Committee that the administrative sharing of the fund for 1976 should be 60% (HMA) and 40% (HCMS). The Auxiliary asked that the allocation of their dues for 1976 be increased by \$3.00 per member due to an increase in national dues. It was voted to allow a budget item of \$9,300 for this purpose. The Finance Committee recommended a \$9,000 budget for the Office of Continuing Medical Education which was increased to \$12,000 by the Council in view of the proposed recommendation for mandatory CME. The amount proposed for the Tel-Med program was reduced to \$500.00. The Fee Survey Committee budget request was reviewed at length. The committee proposes a 1976 revision to the 1970 Hawaii Relative Value Studies, however, the extent of such revision is still unknown and therefore most printers are not able to offer firm bids on the document. Council agreed that there should be a revision of the RVS, that it should be published in loose-leaf notebook form, and that the committee should try to obtain further information on printing costs. Approval was given to a \$15,000.00 budget item for anticipated printing costs. The budget for the HAWAII MEDICAL JOURNAL was approved, however, the recommendation of the Finance Committee to increase the subscription fee to \$12.00 per year failed to pass. A request to include \$10,000 in the proposed budget for a special travel fund for the Hawaii Tumor Registry failed to gain approval. Action on the Finance Committee recommendation that any dues increase be acted upon after the 1976 budget had been considered. The Finance Committee was asked to look into the appropriateness of reserves and give some consideration to actuarial projections for future dues, income and expenses for the Association. The Ad Hoc Committee on Future Recommendations presented five alternatives for office space: (1) No renovation; (2) Renovation of present space at Mabel Smyth Building; (3) Addition of third floor to Mabel Smyth Building; (4) Rent or lease elsewhere; and (5) Build or buy own building. It was voted to eliminate Options 1 and 3. Priority was given to Option 5 requiring a building fund which Council agreed might be accomplished by the following method: All present and future members of the Association after being in practice one year would be asked to contribute \$1,000 to the fund (mandatory contribution) which could be paid at the rate of \$10/month via a bank-check/automatic deduction plan or in a lump sum with a ten per cent discount. Contributions would be refunded if any member in good standing moves, retires, etc. This plan would be contingent upon the advice of legal counsel and accountant. If this option is not acceptable to the House of Delegates, the Council voted to propose that Option 2 (h), renovation of present space with space modifications, etc. as recommended by Architect Ossipoff be pursued. It was further recommended that an appropriation for improvements be approved up to a sum of \$50,000.00 to be shared on a 60-40 basis up to the amount HCMS can appropriate. It was clearly noted that any furnishings would be in addition to this amount. The Ad Hoc Committee on Medical Malpractice presented their recommendations for amendments to the Medical Practice Act. Council went on record as being in favor of mandatory continuing medical education for licensure as recommended by the Ad Hoc Committee. Approval was also given to the entire report of the committee (see report of the Ad Hoc Committee on Medical Malpractice, recommendations of the subcommittee on the Medical Practice Act). Council voted to accept the recommendation of the Legislative Committee to appoint Mr. Kazuhisa Abe as legislative counsel. A budget of \$7,500.00 was approved for this purpose. Drs. Chun-Hoon, Dang, and Lee and Mr. Thorson were appointed to meet with the Hospital Association to discuss matters of mutual concern. Endorsement was given to the PSRO Conditional Grant Plan. The Council was unanimous in commending Dr. Lee for his work as president.

R. VARIAN SLOAN, M.D.

MABEL L. SMYTH MEMORIAL BUILDING

HOUSE ACTION: Filed

The following individuals represented the Hawaii Medical Association on the Mabel L. Smyth Building Board of Management for the year 1975.

Dr. Elmer C. Johnson Chairman
Dr. Grover Batten
Dr. William Dang Alternate

The following individuals represented the Hawaii Nurses' Association on the Mabel L. Smyth Board of Management for the year 1975.

Ms. Virginia Chang
Ms. Jeanne Barry
Ms. Althea Kamau Alternate

The following individuals represented Queen's Medical Center on the Mabel L. Smyth Board of Management for the year 1975.

Mr. Alex Smith
Mr. Lester Gamble Alternate

Building Improvements:

The Board of Management approved the following:

1. A contract to replace the iron grill gate at the back of Mabel Smyth Building with a panic door.
2. A contract to make alterations in a first floor ladies' rest room to provide additional office space.
3. A contract to paint first floor offices, rest rooms and back hall-way.

Nurses & Physicians Exchange

MOTOROLA VOICE RECEIVING RADIOS:

During the past fourteen months, since the use of the new Motorola Voice Receiving Radios, subscriptions have increased from 82 to 188 subscriptions.

Monthly radio messages have increased from 946 in September 1974 to 2,584 for the same month 1975.

The new radio pagers have performed in a highly satisfactory manner which accounts for the continued growth in the usage of this equipment.

Activity Report:

A total of 348,376 calls were processed for the year. A monthly average of 29,031 calls. This amounts to an increase of 40,154 calls for the year or 3,346 calls per month.

Membership:	1974	1975
Physicians	374	385
Registered Nurses	62	56
Licensed Practical Nurses	15	13

ELMER C. JOHNSON, M.D.

HAWAII MEDICAL ASSOCIATION
AUXILIARY

HOUSE ACTION: Filed

Our goal this year was to get more members active through providing a greater variety of projects and programs. Hawaii County has continued with support of their special education centers as well as taking over the staffing of the four Mobile Blood Banks held on their island each year. Together with Honolulu County they are encouraging all members to enroll in a CPR training course. The series of courses began in April, 1975. Honolulu County continues to aid the Medical Library through volunteer staffing and fund raising efforts. In addition, they are assisting in scheduled health screening for the elderly and also planning the distribution of safety placards to aid in resuscitation. Other signs will be made to illustrate the proper procedure for helping choking victims. Kauai and Maui in cooperation with the University extension service deliver a packet of informative materials to new mothers.

Several years of legislative efforts culminated in the passage of a bill which will provide a Health Aid in each public school. The Honolulu County Chairman of this committee testified at a hearing after the program and bill was presented and endorsed by the county membership.

Some "spot" projects have been tried and the short term involvement appealed to many. The Blood Bank in Honolulu was aided by delivering packets to Doctor's offices. Publicity was done for the TV program "Feeling Good" by distributing their posters. We are cooperating with the Immigrant Center and the State Nurses Association in the preparation of language booklets to help non English speaking residents communicate with doctors and nurses. Six members took part in a Leadership Seminar sponsored by the Volunteer Information and Referral Center. Material is being supplied for the health corner at the Library in a suburb. Involvement with and support of other agencies and organizations has been a satisfying experience.

Support of a medical student was the main thrust of the Maui County program. They had a most successful benefit. In the other counties raising funds for AMA-ERF was active and vital but scaled down in emphasis. Plans are already underway for larger events in 1975-76.

The International Health Program aided people in the Philippines, Africa and Viet Nam by sending over one ton of equipment, medicines and clothing. The letters of appreciation which are received are heart warming for those who serve in this way.

WASAMA has boomed. Their growth and activity is wonderful. The group packages and distributes newcomer material to all new student, intern and resident families. They had frequent bake sales at the hospitals to fund this activity. WASAMA is doing most of the actual labor on a cooperative state auxiliary cookbook.

Much has been skipped, but it must be so with active counties and a one page report. There is still a lot to be done in our communities, but many auxiliary members are doing their part to make a dent in some of the problems.

MRS. DONALD (JACKIE) JONES

RESOLUTION NO. 1—Proposed Amendment
to the Bylaws of the Hawaii Medical Association
Regarding Membership

HOUSE ACTION: Not Adopted

RESOLVED that the HMA Bylaws, section 2.01 be changed as follows:

(Proposed deletion ~~crossed-out thus~~)

2.01 Every member in good standing of a component society of this Association shall be a member of this Association ~~and the American Medical Association~~, either as an active, special, or service member. (no further changes to end of Section 2.01).

ARNOLD W. SIEMSEN, M.D.

RESOLUTION NO. 4—Unity

HOUSE ACTION: Adopted

WHEREAS, the physicians in this country are being threatened with complete government control of the practice of medicine and Hawaii is no exception, and,

WHEREAS, this objective is clearly identified in PSRO legislation, Health Manpower legislation, National Health Insurance legislation, and the National Health Planning and Development Act (PL 93-641) and

WHEREAS, to divide and conquer is such a simple, fundamental and effective scheme, and

WHEREAS, unity of county medical society, state medical association, and the American Medical Association is the necessary strong triumvirate to fight governmental control, so therefore be it

RESOLVED, that this House of Delegates reaffirm its support of unified membership, and be it further

RESOLVED that the delegates encourage non members to join, close ranks in unity for the difficult fight that exists now and in the future for the medical profession.

GEORGE H. MILLS, M.D.

RESOLUTION NO. 2—Opposition to the MAC

HOUSE ACTION: Adopted

WHEREAS, the proposed HEW Maximum Allowable Cost (MAC) regulation will directly affect the physician-patient relationship and

WHEREAS, this proposal can precipitate a hardship for a patient in obtaining the medication prescribed by his physician and

WHEREAS, this system does in fact set up a regional drug formulary based on cost only and

WHEREAS, this system could precipitate many problems especially on the neighbor islands and in rural areas, now therefore be it

RESOLVED, that the House of Delegates object to this proposed HEW regulation, and be it further

RESOLVED, that we support the AMA injunction against instituting this regulation and that our congressional representatives be informed of this action by the officers of the HMA and county medical societies.

GEORGE H. MILLS, M.D.

RESOLUTION NO. 20—The Office of Vice President

HOUSE ACTION: Referred to the Bureau of Research and Planning and Bylaws Committee for consideration of the maximum term of office of the HMA President and whether the office of President-Elect is to be maintained or abolished in favor of the office of Vice President. The committees were directed to report their recommendations to the Council and for final action by the 1976 House of Delegates.

WHEREAS the office of President of the Hawaii Medical Association has increased in complexity and responsibility during recent years and

WHEREAS the term of office of one year may inhibit the functioning of the president in an efficient manner because of the time needed to become familiar with total program involvement and

WHEREAS the present bylaws make it impossible for the president to serve more than one term, therefore be it

RESOLVED that the House of Delegates instruct the Bylaws Committee to prepare changes in the bylaws substituting the words "Vice President" for the words "President Elect" wherever they appear in the present bylaws, and make such other changes that may be indicated to make it possible for a president to be re-elected to office at the expiration of his term of office.

WINFRED Y. LEE, M.D.

REFERENCE COMMITTEE ON FINANCE

AD HOC COMMITTEE ON MEDICAL RESEARCH

HOUSE ACTION: Adopted

The Ad Hoc Committee on Medical Research met several times during the year to consider various research projects in which the Association might participate.

HMA staff screened the daily editions of the *Federal Register* to keep apprised of various actions taken by Congress and federal agencies. The committee also reviewed notices of grants and research projects published by the National Institutes of Health. We would like to recommend that this ad hoc committee continue its work in 1976.

HERBERT Y.H. CHINN, M.D.

HAWAII FOUNDATION FOR MEDICAL CARE

HOUSE ACTION: Adopted

The Hawaii Foundation for Medical Care has been relatively inactive since it turned over to the Pacific PSRO, Inc., in 1974, the development of PSRO activities in Hawaii. There have been no Foundation commercial health insurance contracts for some years; however the self-insured, Foundation-sponsored health insurance program of the Roofers Union, Local 221, continues to operate in a most satisfactory manner. The Hawaii Foundation continues to receive an administrative fee from this program for policy determinations and claims review and administrative services. From January 1, 1975, through August 31, 1975, this administrative commission income amounted to \$1,187.50. Expenses for this same period amounted to \$2,087.16. The previously agreed-upon amount owing to the Honolulu County Medical Society for previous cash advances remains at \$31,250.00. The Foundation balance sheet of August 31, 1975, reflects a cash balance of \$5,972.46, of which \$2,500 was received in 1974 as a grant to develop PSRO activities in Hawaii.

WINFRED Y. LEE, M.D.

COMMUNITY RESEARCH BUREAU

HOUSE ACTION: Filed

The research Bureau operates as a fiscal agent for funds designated for charitable, scientific, literary, or educational purposes. The Bureau had a very active period from November of 1973 to the end of July, 1975. During this time, it received grants amounting to \$1,118,117.00. A financial statement of receipts and expenditures for this period is on file in the HMA Office. The Bureau is not in need of any funding from the Hawaii Medical Association for the coming year.

B. ALLEN RICHARDSON, M.D.

COMMISSION ON MEDICAL SERVICES

HOUSE ACTION: Adopted with the recommendation that the new RVS be published in looseleaf notebook form and that a budget of \$15,000 be provided for printing expenses.

The following are the reports of the three committees under the Commission on Medical Services.

Fee Survey—Maurice W. Nicholson, M.D., Chairman

The Fee Survey Committee published an addendum to the 1970 Hawaii Relative Value Studies this year. The committee also considered the feasibility of publishing a new RVS as requested by the House of Delegates in 1974. In late June, the 1974 California RVS was received and reviewed by the various specialty societies and it was agreed that a new Hawaii RVS should be published. The committee agreed that the 1970 HRVS should be used as the base and new procedures added as necessary rather than adopting the California RVS in total. Although it will be several months before the committee can assess the extent of the additions to the HRVS, we are including a budget item since it is anticipated the printing will occur toward the end of 1976. Until such time as all changes and additions have been completed, the publisher can only present a very wide range for printing costs.

The committee has also held several meetings regarding alleged discriminatory practices of insurance carriers and met recently with the Department of Regulatory Agencies and the deputy insurance commissioner regarding the manner in which HMSA handles payments to participating and non-participating physicians. This will be pursued further in the coming year.

Recommendations:

- (1) The committee recommends the publication of a new Hawaii Relative Value studies in 1976 using the 1970 HRVS as the base and adding new procedures as necessary, thus enlarging the choices and terminology of various sections to more efficiently describe and code services.

- (2) The committee recommends that the 1976 RVS be published in loose-leaf notebook form. This form will allow the reprinting of only those pages where changes or additions are made and should eliminate the need for frequent reprinting of the entire RVS. (Note: The 1974 California RVS is printed in such a manner although the actual notebook itself was not provided).

Budget Request:

Printing, 1976 HRVS, 3,000 copies

Estimated Costs:

- (1) If HRVS is reprinted exactly as is at present without changes, cost would be\$ 4,000.00
- (2) If HRVS is reprinted with 30 additional pages of type-setting, cost would be\$ 7,500.00
- (3) If HRVS is completely reset in type and an additional 88 pages are required (approximate number of pages in 1974 California RVS), the cost will be\$19,000.00

In 1970, a free copy was provided to each member of the HMA (1,000 copies) and the remaining copies are being sold at \$10.00 per copy.

Looseleaf folders: 1,000 copies @ 1.51\$1,510.00

Economic Evaluation and Adjustment Committee—Chew Mung Lum, M.D., Chairman

Although this committee did not meet formally during the year, several of the members met informally with the Physician's and Dentist's Action Group in an effort to seek remedial legislation for the amounts available in the Medicaid program for professional services. Testimony on the usual-and-customary concept for reimbursement of physician's services was presented to several committees of the legislature. The legislature failed to appropriate sufficient funds to remedy the situation and instead asked that the next budget (1977) submitted by the governor include Medicaid payments for usual-and-customary charges by physicians and dentists.

Workmen's Compensation Committee—Albert C.K. Chun-Hoon, M.D., Chairman

The Workmen's Compensation Committee was able to work cooperatively with the former Director of the Department of Labor, Mr. Robert Hasegawa, in resolving some of the conflicts which the Association had with the Workmen's Compensation Fee Schedule. Prior to his leaving at the termination of his job as Director of the Department of Labor, Mr. Hasegawa and his deputies in the Bureau of Workmen's Compensation revised the Workmen's Compensation Fee Schedule. These revisions included: (1) The elimination of the double standard of payment for certified and non-certified specialists. (2) The use of a 5-digit coding system corresponding to the 1970 Hawaii RVS. (3) The broadening of the medicine section to include different fees for office visits, home visits, hospital visits and consultations of varying complexities, rather than one standard fee for each of these types of services. (4) The inclusion of a number of new procedures within the Fee Schedule which had not been present in the old schedule. All of those changes had been supported by the HMA.

The Committee met with the Director of the Workmen's Compensation Bureau and his deputies and was able to resolve some problems, which existed because of the use of some new procedures.

The Committee recommends: (1) That the Workmen's Compensation Committee of the HMA continue to cooperate with the Bureau of Workmen's Compensation. (2) That efforts continue to be made with the Bureau of Workmen's Compensation and its Medical Director to improve the Vocational Rehabilitation Program for the injured workman.

ALBERT C.K. CHUN-HOON, M.D.

RESOLUTION NO. 17—The Reimbursement to Physicians by DSSH for Medical Services Rendered to its "Clients".

HOUSE ACTION: Adopted

WHEREAS there continues to exist a system of markedly discounted payments by the State of Hawaii on behalf of its welfare recipients, and

WHEREAS in 1975 the DSSH authorized only a slight increase in the amount of reimbursement to physicians, this increase being a percentage based on charges frozen by the Feds several years ago, which increase did not begin to make up for inflation and the rise in the cost of doing business, and

WHEREAS the poor and the near-poor are, therefore, being denied the right of free choice of physician and hospital mandated to them by law, denied primarily because many physicians, and particularly those in group practice, cannot afford to see or treat these people without taking a considerable loss if they do, now, therefore, be it

RESOLVED that this House of Delegates instruct the legislative committee of the HMA to proceed at once, with legal counsel, to draw up a bill and have it introduced in the 1976 Legislative session, and be it further

RESOLVED that this bill rectify the injustice done to both the welfare patient and his physician, by devising some method whereby 100% remuneration be made possible to physicians up to the maximum amount Federal rules permit the DSSH to pay.

J.I.F. REPPUN, M.D.

HAWAII MEDICAL JOURNAL

HOUSE ACTION: Adopted

After nearly a year of publishing the Journal monthly instead of bimonthly, we find ourselves—though not actually embarrassed by having become a source of potentially taxable income—financially in the black. It is not certain that we will still be there on December 31, but we are there at this writing.

The Journal has slimmed down a lot in the achievement of this state; most issues have had to be limited to one scientific article. We are emphasizing communication of Association news and personal news items, and with as short a delay from writing to mailing as possible—sometimes as little as 10 days.

An active Publications Committee under Dr. William Moore's chairmanship has met monthly to evaluate each issue and the plans for the next. Doris Jasinski still is in charge of manuscript editing and Henry Yokoyama still writes the Notes and News section. Mr. Thorson furnishes us the copy for the Association Bulletin which occupies the center of each issue. News items are being actively solicited from hospitals and the Medical School, with fair success, in the hope that such will make the Journal more meaningful to readers.

A conference with medical school representatives regarding possible active participation of the medical school in production of the Journal has unfortunately led to nothing more than the offer to furnish us with news items about the school.

We have now 16 articles awaiting publication. Of the last 3 submitted, 2 were accepted for publication, probably next May or June, and one was rejected on the ground that it was not basically relevant to medicine in the Pacific area and did not fulfill the other criterion of providing information useful in medical practice.

We recommend that the House of Delegates approve the continued publication of the HAWAII MEDICAL JOURNAL on the same basis during 1976.

HARRY L. ARNOLD, JR., M.D.

REPORTS OF THE TREASURER AND FINANCE COMMITTEE, AD HOC COMMITTEE ON FUTURE RECOMMENDATIONS, SITE COMMITTEE, RESOLUTION NO. 23 AND RESOLUTION NO. 24.

HOUSE ACTION: The House of Delegates first considered the recommendation of the Ad Hoc Committee on Future

Recommendations and agreed that Option 5 of the report, to build or buy a building or condo space for HMA offices be given top priority by the House. It was voted to implement this recommendation and the Council was authorized to proceed to acquire any acceptable new building if funds are available.

Resolution 23 was adopted as a method whereby monies could be developed to acquire a new building. The Council was directed to work out the details of the loan plan.

The recommendations of the Finance Committee to increase the subscription fee for the Journal and HMA dues were not accepted by the House.

It was voted to approve the Common Fund ratio of 60 (HMA) and 40 (HCMS) for 1976.

It was voted to approve a Council Contingency Fund of \$10,000 and a fund for Special Authorized Expenses of \$10,000 if funds are available.

Resolution No. 24 was adopted.

The budget for 1976 as recommended by the Council was approved reflecting the actions taken by the House of Delegates regarding membership dues, Journal subscriptions; and expenses for CME, printing of the RVS, committee expenses, the Council Contingency Fund, and fund for Special Authorized Expenses. (The 1976 budget as adopted by the House appears in the report of the Treasurer)

FINANCE COMMITTEE AND TREASURER

HOUSE ACTION: Adopted with deletion of recommendations 2 and 3.

You have before you the proposed budget for 1976. You will note that the budget proposed by the finance committee is in balance.

The Council has suggested some modifications in this budget, some of them resulting from submissions by committees that were received too late for the finance committee to consider. The committee has no particular quarrel with these proposals for increases in the expenditure side of the budget.

Your committee does feel, however, that if the expense side of the budget is to be increased, then consideration must be given to the income side and the committee recommends strongly that the income elements, represented by a dues increase be given favorable and consistent consideration by the House of Delegates so that a balanced budget may be adopted.

You will note that the budget reflects the fiscal experience through the month of August along with an educated guess as to what will happen during the following four months to the end of 1975. You will note that we will not be suffering a total net loss for 1975 but we must point out that the net income level is derived from funds that are not items that can be planned as regular income, namely, funds derived from cost reimbursement for federal projects. The Finance Committee does not include such income when preparing the budget.

We have enjoyed a substantial increase in revenue derived from the investment of short term surplus funds in commercial paper and short term government obligations. Our major revenue is derived during the early part of the year and we use this surplus up as the year goes on. During the period that we have an excess over operating needs this money is invested. We will not know the full amount of this income until the end of the year. We do know that there will be a balance available for the establishment of a small allocated reserve for future planning if the House of Delegates so directs.

In years past the fiscal year of the association ended June 30. We changed the fiscal year to the calendar year in 1971. Under the old system we ended the year right at the end of our high income period and what we saw in our fiscal year end statements as "reserves" was nothing other than operating funds for the balance of the year. We now have a real and accurate reflection of our financial condition at year's end.

The Finance Committee endorses the position taken by the House of Delegates and the Council that federal funds not be included in the budget projections, but that we make every effort to develop a budget reflecting our ability to live on our own resources.

HMA is operating a major financial structure through the combined offices of HCMS and HMA. During the calendar year of 1974, more than \$2,700,000 went through the accounts of the various organizations operated out of our administrative office. Only a small portion of this is reflected in the operating budget of HMA but we must consider the total responsibility in developing our internal mechanisms.

We have attempted to give you prudent and effective financial management during the past year. We do believe that the House of Delegates should grant more latitude to the Council for emergencies. For emergency purposes, the House has given permission to authorize up to \$5,000 for unbudgeted items. During the past year it became necessary for the HMA to pick up travel costs for one of our projects that had not been budgeted. This exhausted all but a few dollars of the total allocation.

The following recommendations are submitted for your considerations:

- (1) Recommend approval of the Common Fund ratio of 60 (HMA)—40(HCMS) for 1976.
- (2) Recommend that the Journal subscription be increased to \$12.00 per year.
- (3) Recommend that the dues for HMA be increased by \$20.00.
- (4) Recommend that the Council Contingency Fund be \$10,000 if funds are available.
- (5) Recommend that Special Authorized Expenses be \$10,000 if funds are available.
- (6) Recommend that the budget for 1976 be accepted.
- (7) Recommend that the House approve Resolution No. 23 covering the "Dang Plan" which will provide for an orderly accumulation of reserves for the Association for the future.
- (8) Recommend favorable consideration of Resolution No. 24 which provides for the Finance Committee to allocate to reserves certain funds in excess of current needs, the amount to be determined by the Finance Committee with the approval of the Council.

GROVER H. BATTEN, M.D

REPORT OF THE AD HOC COMMITTEE ON FUTURE RECOMMENDATIONS

HOUSE ACTION: Adopted with the exception of Recommendation 3 which was not adopted in view of the possibility of an attractive new office site which would be available in the near future.

This committee was appointed by the Council to study various alternatives relative to new office space for the Association. Listed below are five options:

- (1) No renovation of present office space. No costs.
Advantage: None, except spend no money
Disadvantage: Same deal
- (2) Renovation of present space—Mabel Smyth
 - (a) Carpet, drapes, some furnishings and expansion of conference room \$15,000—\$18,000
Advantage: Noise control
Disadvantage: Spend money and wind up with same arrangement of space
 - (b) Space modifications, carpet, drapes recent Ossipoff plan \$40,000.00
(The final plans can be modified to meet a stated budget for example: \$30,000)
Advantage: Well planned space allowing 3 more employees. Attractive environment.
Disadvantage: Spend money on building in which no equity (however, similar to improving lease space)

HAWAII MEDICAL ASSOCIATION

Budget for 1976—As Approved by the House of Delegates

	Current Year Date 8/31/75	Projected Dec. 31, 1975	Budget For 1975	Budget For 1976
<i>INCOME:</i>				
Membership Dues	181,352.50	181,700.00	178,400.00	184,000.00
Journal	41,689.80	51,000.00	46,500.00	53,000.00
Annual Meeting	—0—	—0—	25,000.00	25,000.00
Annual Roster	810.00	1,500.00	6,600.00	1,500.00
Indirect Cost Reimb. (EMS)	45,645.43	65,000.00	—0—	—0—
Indirect Cost Reimb. (TUMOR)	14,782.64	22,000.00	—0—	—0—
Indirect Cost Reimb. (Others)	—0—	—0—	—0—	—0—
Interest Earned	—0—	3,600.00	2,000.00	3,500.00
Miscellaneous	107.25	250.00	500.00	300.00
Common Fund Revenues	3,058.81	4,500.00	5,000.00	4,500.00
Dues Collection Services	1,440.15	2,500.00	2,000.00	3,000.00
Pacific PSRO (Services)	3,771.55	12,000.00	12,780.00	12,500.00
Pacific PSRO (Salary Reimb.)	13,884.70	20,000.00	18,900.00	22,000.00
Fee Survey	1,245.75	1,250.00	1,000.00	1,500.00
Continuing Medical Education	1,500.00	1,600.00	1,600.00	1,600.00
RMP—CME	3,491.75	3,491.00	—0—	—0—
Total Income	<u>312,830.33</u>	<u>370,391.00</u>	<u>300,280.00</u>	<u>312,400.00</u>
<i>EXPENSES</i>				
Auditing	2,912.00	4,500.00	5,000.00	5,000.00
Council Expenses	2,032.82	3,500.00	4,000.00	4,000.00
Donation	—0—	—0—	100.00	100.00
Dues & Subscription	642.05	650.00	500.00	650.00
HAMPAC	—0—	500.00	500.00	500.00
Library Contribution	100.00	100.00	100.00	100.00
Insurance	75.93	500.00	600.00	500.00
Legal Counsel	—0—	—0—	—0—	—0—
Meeting Expenses	2,826.52	5,000.00	5,000.00	4,000.00
Miscellaneous	80.38	200.00	500.00	200.00
Postage	1,318.85	2,500.00	3,500.00	3,000.00
President's Assistant	4,250.00	8,250.00	12,000.00	12,000.00
President's Contingency Fund	187.60	1,000.00	1,000.00	1,000.00
Repairs & Maintenance	—0—	200.00	200.00	200.00
Stationery, Printing & Supplies	23.77	200.00	500.00	300.00
Special Authorized Expenses			—0—	10,000.00
Taxes—Payroll	453.00	900.00	1,000.00	1,000.00
Telephone & Telegram	893.20	1,800.00	3,000.00	2,500.00
Travel	11,398.95	12,500.00	5,000.00	10,000.00
Auxiliary	6,656.00	6,800.00	7,000.00	9,300.00
Committee Expenses	782.63	7,500.00	9,250.00	10,000.00
Journal Expenses	31,141.81	50,000.00	46,892.00	54,000.00
Annual Meeting Expenses	—0—	3,000.00	21,000.00	21,000.00
Roster Expenses	—0—	1,500.00	7,100.00	—0—
Furniture & Fixtures—Depreciation	—0—	1,000.00	1,000.00	1,000.00
Continuing Medical Education	147.72	500.00	7,000.00	12,000.00
Fee Survey	86.25	500.00	800.00	15,000.00
RMP—RUCH—CME	3,777.95	3,778.00	—0—	—0—
Council Contingency	4,659.56	4,659.00	—0—	10,000.00
Total Expenses—General	<u>74,446.99</u>	<u>121,537.00</u>	<u>142,542.00</u>	<u>187,350.00</u>
<i>COMMON FUND EXPENSES</i>				
<i>HMA SHARE—60% of Total</i>				
Salaries	64,349.34	99,999.00	94,000.00	107,400.00
Auto Allowance	1,385.07	1,920.00	2,000.00	2,280.00
Computer Reports	213.85	270.00	300.00	300.00
Dues & Subscriptions	149.40	200.00	400.00	300.00
Insurance & Bond	1,283.52	1,800.00	4,000.00	2,400.00
Lease Rent on Office Equipment	1,843.66	2,520.00	3,000.00	2,700.00
Legal & Professional	1,248.00	1,680.00	3,000.00	2,400.00
Meeting Expenses	216.74	300.00	200.00	300.00
Office Supplies	5,156.03	6,900.00	8,000.00	7,500.00
Postage	1,230.72	1,680.00	200.00	2,400.00
Rent	6,228.72	9,600.00	10,000.00	11,400.00
Repairs & Maintenance	703.84	1,050.00	1,000.00	1,200.00
Retirement Contribution & Expenses	5,608.51	7,800.00	15,000.00	7,800.00
Telephone & Telegram	862.35	1,200.00	250.00	1,200.00
Taxes (FICA, U. C, FUTA)	7,082.41	6,120.00	7,000.00	7,200.00
Travel	—0—	1,200.00	3,000.00	3,000.00
Miscellaneous	—0—	—0—	200.00	300.00
Total Common Fund	<u>97,562.16</u>	<u>143,240.00</u>	<u>151,550.00</u>	<u>160,080.00</u>
Total Expenses				
HMA General + HMA Common Fund	<u>172,009.15</u>	<u>264,777.00</u>	<u>294,092.00</u>	<u>347,430.00</u>
<i>NET INCREASE (DECREASE) IN FUND</i>	<u>140,821.18</u>	<u>105,614.00</u>	<u>6,188.00</u>	<u>(35,030.00)</u>

COMMITTEE BUDGET—1976
As Approved by House of Delegates

	Year to Date 8/31 75	Projected 12/31 75	Budget 1975	Budget 1976
<i>LEGISLATIVE</i>				
Legal Counsel		2,500.00	7,500.00	7,500.00
Dinner & Entertainment				
Today's Health	304.00	304.00	150.00	300.00
Miscellaneous	83.20	83.20	100.00	100.00
Total	<u>387.20</u>	<u>2,887.20</u>	<u>7,750.00</u>	<u>8,200.00</u>
<i>PUBLIC AFFAIRS</i>				
News Media Awards	—0—	800.00	800.00	800.00
Science Fair	186.43	186.43	200.00	200.00
Physician's Questionnaire	—0—	—0—	300.00	300.00
Tel-Med:				
Administrative Services			—0—	
Rent			—0—	
Misc. Services & Supplies			—0—	500.00
Total	<u>186.43</u>	<u>986.43</u>	<u>1,300.00</u>	<u>1,800.00</u>
<i>INTERPROFESSIONAL RELATIONS</i>				
Association of Professions		—0—	200.00	—0—
<i>OTHER COMMITTEES</i>				
Medical Education	209.00	209.00	—0—	—0—
TOTAL COMMITTEE EXPENSE	<u>782.63</u>	<u>4,082.63</u>	<u>9,250.00</u>	<u>10,000.00</u>
<i>FEE SURVEY COMMITTEE</i>				
<i>INCOME</i>				
Sale of RVS	1,245.75	1,250.00	1,000.00	1,500.00
<i>EXPENSES</i>				
Spot Survey			600.00	
Printing	86.25	500.00	200.00	15,000.00
Total Expenses	<u>86.25</u>	<u>500.00</u>	<u>800.00</u>	<u>15,000.00</u>
NET INCREASE (DECREASE)	<u>1,159.50</u>	<u>750.00</u>	<u>200.00</u>	<u>(13,500.00)</u>
<i>CONTINUING MEDICAL EDUCATION</i>				
<i>INCOME</i>				
Subsidies from Hospitals	1,550.00	1,600.00	1,600.00	1,600.00
<i>EXPENSE</i>				
Secretary	—0—	—0—	3,600.00	3,600.00
Consultant & Travel	102.37	500.00	3,000.00	8,000.00
Publication—Calendars	45.35			
TOTAL EXPENSE	<u>47.72</u>	<u>500.00</u>	<u>7,000.00</u>	<u>12,000.00</u>
INCREASE OR DECREASE IN FUND	<u>1,402.28</u>	<u>1,100.00</u>	<u>(5,400.00)</u>	<u>(10,400.00)</u>

HAWAII MEDICAL JOURNAL
PROPOSED BUDGET—1976

	Current Year to Date 8/31/75	Projected for Year	Budget 1975	Finance Committee Budget 1976
<i>INCOME</i>				
Journal Advertising (local)	12,863.50	16,000.00	22,800.00	17,000.00
Journal Advertising (National)	20,942.80	26,000.00	15,700.00	28,000.00
Journal Sales & Subscriptions.....	7,883.50	8,000.00	8,000.00	8,000.00
Total Income.....	<u>41,689.80</u>	<u>50,000.00</u>	<u>46,500.00</u>	<u>53,000.00</u>
<i>EXPENSES</i>				
Assistant Editor	4,890.25	7,200.00	7,200.00	8,000.00
Copyrights	54.00	72.00	72.00	72.00
Commission Paid	3,319.02	6,000.00	6,000.00	7,200.00
Discounts Allowed	2,634.55	4,000.00	4,000.00	4,800.00
Miscellaneous	45.00	100.00	—0—	100.00
Postage	410.63	600.00	300.00	900.00
Printing	19,709.46	32,000.00	29,220.00	33,000.00
Stationery & Supplies	78.90	100.00	—0—	100.00
Insurance	—0—	100.00	100.00	100.00
Total Expenses	<u>31,141.81</u>	<u>50,172.00</u>	<u>46,892.00</u>	<u>54,272.00</u>
NET INCREASE (DECREASE)	<u>10547.99</u>	<u>(172.00)</u>	<u>(392.00)</u>	<u>2,128.00</u>

HMA-HCMS COMMON FUND
BUDGET FOR 1976—As approved by House of Delegates

	HMA Allocation 60%	HCMS Allocation 40%	1976 Budget
REVENUES:			
Printing, Addressing, etc.	4,500.00	3,000.00	7,500.00
PSRO Services	12,500.00	8,330.00	20,830.00
PSRO Salary Reimb.	22,000.00	14,670.00	36,670.00
Total Income	39,000.00	26,000.00	65,000.00
EXPENSES:			
Salaries	107,400.00	71,600.00	179,000.00
Auto Allowances	2,280.00	1,520.00	3,800.00
Computer Reports	300.00	200.00	500.00
Dues & Subscriptions	300.00	200.00	500.00
Insurance & Bond	2,400.00	1,600.00	4,000.00
Lease Rent on Office Equipment	2,700.00	1,800.00	4,500.00
Legal & Professional	2,400.00	1,600.00	4,000.00
Office Supplies & Expenses	7,500.00	5,000.00	12,500.00
Postage	2,400.00	1,600.00	4,000.00
Rent	11,400.00	7,600.00	19,000.00
Repairs & Maintenance	1,200.00	800.00	2,000.00
Retirement Plan	7,800.00	5,200.00	13,000.00
Taxes (FICA, U/C, FUTA)	7,200.00	4,800.00	12,000.00
Telephone & Telegram	1,200.00	800.00	2,000.00
Travel	3,000.00	2,000.00	5,000.00
Meeting & Promotions	300.00	200.00	500.00
All Others	300.00	200.00	500.00
Total Expenses	160,080.00	106,720.00	266,800.00
Net Decrease in Fund	(121,080.00)	(80,720.00)	(201,800.00)
 (c) Renovation of present space plus balcony (Balcony: 500 sq. ft. @ \$50) Add to (b) \$25,000.00 Advantage: Additional office space Disadvantage: Expensive and it would tend to destroy the auditorium by decreasing capacity at time when membership is growing; interfere with acoustics; pro- jection booth lost.			
(3) Add third floor to Mabel Smyth Building Cost estimate: If possible without major structural al- terations \$65 @ \$65/sq. ft. Approximately 10,000 sq. ft. \$650,000.00 If outside supporting columns and foot- ings are needed, add \$50-60,000 to the per foot cost \$ 50,000.00 \$700,000.00 Advantage: Additional space for HMA Disadvantage: Major reconstruction of Mabel Smyth Building Possible problems with height limits Parking problems			
(4) Rent or lease elsewhere Grosvenor International Building (20,000 sq. ft. @ \$.67 sq. ft.) There are still plenty of vacancies in the building. (The building has some problems: (1) location and (2) parking). Apparently there is still a possibility for us to drive a hard bargain on a lease. Advantage: More space. Possible advantage: Quasi-equity through sublet po- tential at rate higher than rent in the event HMA and Company move Disadvantage: Rent receipts only			
(5) Build or buy own building or condo space New building construction, finished space \$52/sq. ft. \$1,040,000 Preliminary estimate on required space—20,000 sq. ft. If land is purchased, costs run \$20.00/sq. ft. and up \$ 400,000			
Lease land for commercial property—annual lease rental is approximately 7% or 8% of land value per annum Needed land for single purpose building—20,000 sq. ft. For multiple purpose building—land area determined by type and use of building Construction: finished space \$52/sq. ft. Unfinished loft space—finishing left to tenants \$43/sq. ft. Combination possibilities: HMA ownership of building with rental of units Owners condo commercial residents Limited partnership, etc. Residential: Condo residential units seem definitely to be overbuilt. Hawaiian Electric reports 7,500 unused loops—it is not known how many other unsold condos there are under a single meter. Hawaii Housing Authority: Has a surplus of units. The cost of the building regardless of where it is built will be the same. The only significant variables are the cost of the building plus acquisition of land. Financing: Mortgage: 80% maximum at 10-11% interest. Funding: It is impossible to really investigate the pros- pects of owning our own quarters without front mon- ies. Nor do we have a budget for new rental/lease quarters. The only money presently available is that of the "Physician's Benevolent Fund" presently at \$44,312.96 (at cob 8/31/75). This would be a down payment on a \$221,565 building of 4,261 sq. ft.—inadequate for even present needs. Additional money could come from: (1) Assessment of HMA members (e.g. \$1,000 per mem- ber): Perhaps not an attractive plan at this time. (2) Voluntary contribution: Doubt if it would generate enough money. (3) "Dang Plan": Would develop a building fund with mandatory contributions by each member of \$1,000 which can be paid via bank/automatic deduction at the rate of \$10.00 per month over a ten-year period. Cash payments in full would be given a discount.			

Contributions to the fund would be refunded (without interest) if a member retired, moved, resigned, etc. All members who have been in practice one year or more would be required to contribute. It is anticipated that \$1 million could be accumulated over a 10-year period. It might also be possible to offer the signed bank notes as collateral for a more immediate bank loan.

RECOMMENDATIONS:

- (1) The Council of the HMA recommends that Option 5 be given top priority by the House of Delegates.
- (2) It is recommended that the mandatory contribution plan as described above be implemented pending approval of legal counsel and the accountant in order to develop the monies necessary for Option 5.
- (3) In the interim, it is recommended that Option 2(b) be pursued and that an appropriation for improvements be approved up to a sum of \$50,000 to be shared by the Common Fund up to an amount HCMS can appropriate. It should be clearly noted that these funds would not cover costs of furnishings.

WINFRED Y. LEE, M.D.

SITE COMMITTEE

HOUSE ACTION: Adopted

The ad hoc Site Committee reviewed a number of proposals relative to new office space for the Association. Proposals for ownership through building new space, rentals, condominium ownership and other mechanisms were explored.

It is noted that with the total combination of all activities, including the HMA-HCMS core staff, the EMS Project staff, the Tumor Registry, and the Bureau of Medical Economics, current space occupancy is about ten thousand square feet. For this we are paying a total of about \$75,000 per year occupancy costs. If the PSRO becomes an operative entity, additional space will be required. Our minimum target for space then should be about twelve thousand square feet.

We have learned one very specific thing in this exploratory work. We have learned that we are wasting our time and efforts to try to get something for nothing. It is basic that we must have financial backing within our own organization if we are to make any moves toward the ultimate ownership of our own home. For this reason we strongly recommend that the association move toward the setting up of a fund that can be available for housing our organization.

Until such a fund of \$500,000 or more to develop a building with income producing space to retire a mortgage and give us eventual total ownership is reached, we have no leverage. We could manage space for ourselves for less, but would have no income producing potential.

The committee then recommends:

That HMA proceed to establish a plan for the funding of a building reserve in order to plan for our occupancy needs of the future.

GROVER H. BATTEN, M.D.

RESOLUTION NO. 23—Dang Plan

HOUSE ACTION: Adopted

WHEREAS the Hawaii Medical Association has been concerned with the need for future expansion and

WHEREAS such expansion is dependent on the ability of the association to finance such a program, therefore be it

RESOLVED that the House of Delegates approve the application of a plan referred to as the "Dang Plan" to the membership that will provide for an orderly accumulation of funds over a period of time. The plan will involve the contribution by each present and future member of \$1,000, payable over a period of ten years at the rate of at least \$100 per year. Payments in full or on any remaining balance of \$100 or more, would be given a ten percent (10%) discount. Such contributions would be refunded (without interest) upon a member's retirement or if the member moves

from Hawaii, resigns, or in the event of the death of a member. Contributions would not be applied to a new member until after the first year of practice. It is anticipated that approximately one million dollars could be realized by the end of ten years. It is suggested that a mechanism be developed whereby the member could authorize a regular payment to the fund through automatic bank payments and be it further

RESOLVED that the Council proceed immediately with the accumulation of data to develop the details of such a plan covering the actuarial projections, the administration as a trust fund, and the probable tax status of such a program, and to implement this plan as soon as feasible.

HMA FINANCE COMMITTEE

RESOLUTION NO. 24—Reserve Accounts

HOUSE ACTION: Adopted

WHEREAS, from time to time there are certain funds that become available to the Hawaii Medical Association and

WHEREAS the association has never established an allocated reserve separate from the general fund except for the Physicians Benevolent Fund, and

WHEREAS it is deemed wise for such an allocated reserve to be established for surplus funds from whatever source derived, therefore be it

RESOLVED that the Finance Committee with the approval of the Council be authorized to establish an allocated reserve account and deposit such sums therein as may be deemed expedient.

HMA FINANCE COMMITTEE

ANNUAL REPORT FOR HAMPAC ACTIVITIES

HOUSE ACTION: Filed

The Hawaii Medical Political Action Committee (HAMPAC) did not meet during the year. However on November 12, 1974 your HAMPAC chairman furnished a report to HAMPAC Directors, HMA President and County Society Presidents for dissemination to fellow physicians and auxiliary members of how HAMPAC supported candidates fared in Hawaii's 1974 primary and general elections. In attesting to the bi-partisan nature of HAMPAC supported it was noted that of the twenty candidates supported for elective office, eleven were Democrats and nine were Republicans of the twenty receiving HAMPAC support, fifteen were successful candidates—nine Democrats and six Republicans. Of the twenty HAMPAC supported candidates four were from Hawaii, four from Maui, eleven from Oahu and one representing rural Hawaii at large.

Total 1975 HAMPAC membership of 186 dropped from a 1974 total of 216. There were 998 physicians eligible for HAMPAC membership in 1975 with only 176 or 18% participating. Less than 1% of the auxiliary were participating members. With upcoming 1976 being a key election year and in light of the many important issues currently affecting a physician's practice which are being considered by our elected representatives and which will require legislative action it is incumbent that HAMPAC receive maximum participation and support from HMA physicians and their spouses. HAMPAC will continue to solicit new membership renewals for 1976.

Recommendations:

1. That HMA actively encourage physicians and their spouses to acquaint themselves with the legislative issues affecting the practice of medicine and to inform their elected representatives of the stand of organized medicine.
2. That \$200 be included in HMA's 1976 budget for HAMPAC education and administrative expenses.

L.Q. PANG, M.D.

NOMINATING

HOUSE ACTION: Adopted

The Nominating Committee met twice to receive nominations for needed offices of the Association. The following slate of nominees was submitted to be elected by the House of Delegates:

- President-Elect Calvin C.J. Sia
- *Treasurer William F. Moore, Jr.
- *AMA Delegate (one to be elected Herbert Y. H. Chinn
George H. Mills
- *Alternate AMA Delegate William E. Iaconetti
- *Councillor from Hawaii Verne Adams
- *Councillor from Maui Sakae Uehara
- *Councillors from Honolulu Ann B. Catts
(four to be elected) Albert C.K. Chun-Hoon
John W. Edwards
George Goto
Andrew L. Morgan
Henry T. Oyama
J.I.F. Reppun

*2-year terms

All nominees have been contacted and have agreed to serve if elected.

ALBERT C.K. CHUN-HOON, M.D.

ELECTION

HOUSE ACTION: The report of the Nominating Committee was presented and the President called for nominations from the floor. There were no further nominations for the offices of President-Elect, Councillor from Hawaii, Councillor from Maui, and Councillors from Honolulu.

Dr. Grover H. Batten was nominated for the office of Treasurer.

Dr. Herbert Y.H. Chinn asked that his name be withdrawn from the ballot for the office of AMA Delegate. There were no further nominations and Dr. George H. Mills was elected unanimously.

Dr. Herbert Y.H. Chinn was nominated for the office of Alternate AMA Delegate.

Ballots were distributed and tellers were appointed as fol-

lows: Drs. Vincent Aoki, George Ewing, Roy Kuboyama, and Neal Winn.

The following were elected:

- | | |
|---------------------------|-----------------------|
| President-Elect | Calvin C.J. Sia |
| Treasurer | Grover H. Batten |
| AMA Delegate | George H. Mills |
| Alternate AMA Delegate | Herbert Y.H. Chinn |
| Councillor from Hawaii | Verne Adams |
| Councillor from Maui | Sakae Uehara |
| Councillors from Honolulu | Ann B. Catts |
| | Albert C.K. Chun-Hoon |
| | George Goto |
| | J.I.F. Reppun |

The Nominating Committee was elected as follows: Win-fred Y. Lee, Herbert Y.H. Chinn, Roy Kuboyama, Arnold Siemen, Andrew Morgan (Honolulu); Ernest Bade (Hawaii), Marion Hanlon (Maui), Peter Kim (Kauai).

NEW BUSINESS

The members of the House gave retiring President Win-fred Y. Lee a standing ovation. The meeting adjourned at 5:30 p.m.

R. VARIAN SLOAN, M.D.

AWARDS

Medical Journalism

- Harold Hostetler—Honolulu Advertiser
- Robert Weiser, Sr.—KUMU Radio

Sportsmen's Awards

Tennis:

Leabert Fernandez and Yutaka Yoshida—Doubles champions

Golf:

- President's Trophy—Ernesto Orinion
- Robert M. Miyamoto Perpetual Trophy—Ernesto Orinion
- John M. Felix Perpetual Trophy—Nobuyuki Nakasone
- George H. Mills Perpetual Trophy for Pharmaceutical Representatives—Ray Maruyama

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance

SPECIAL EVENTS:

1976

- January 17-24 Prenatal Medicine; USC at Royal Lahaina, Maui
- January 18 Medical Emergencies in the Elderly, presented by the American Geriatrics Association and the HMA, to be held at Straub Clinic, 8:30-4:30. Speaker: Thomas Criley, M.D.
Contact: L. Clagett Beck, M.D., 523-2311.
- February 7-14 Surgical Diagnosis and Therapy; The Phil Thorek Postgrad Courses, 850 W. Irving Pk. Rd., Chicago, IL 60613 at Maui Surf Hotel, Maui; fee: \$300.
- February 9-11 "Workshop in Perinatal Infections" sponsored by ACOG & Kapiolani Hospital, at Kuilima Hotel (North Shore Oahu); 12 hours credit. For further information contact Wilma B. Schiner, R.N., Director of Training & Education, Kapiolani Hospital (955-6611).
- February 15-19 Sports Medicine for Primary Physicians; Kuilima Hotel, Oahu; contact: Joy Lewis (for Dr. Richard Strauss), University of Hawaii Conference Center, 2500 Dole Street, Honolulu 96822.
- February 23-March 1 Practice Management for the Health Team; Medical Computer Services Association, 315-1107 NE 45th, Seattle, WA 98105; at Kauai Surf Hotel, Kauai; 20 hours credit.

The seminars on "Sexual Counseling: Office Management of Sexual Problems" sponsored by the ACOG and University of Hawaii will be held on the following dates: (20 hrs. credit)

- | | | |
|----------------|----------------|----------------|
| January 19-23 | April 19-23 | December 20-24 |
| February 23-27 | October 18-22 | |
| March 22-26 | November 22-26 | |

For further information, write to:

American College of Obstetricians & Gynecologists
Department of Continuing Education
1 E. Wacker Drive, Suite 2700
Chicago, IL 60601

OUT OF STATE

1976

Courses of American College of Chest Physicians:

- January 26-29 "The Young Lung" at Tamarron in Durango, Colorado, 16 hours credit.
- February 2-6 "Practical Problems in Clinical Cardiology" at the Konover Hotel in Miami Beach, Florida, 24 hours credit.

For further information, write to:

Dale E. Braddy, M.S.
Director of Education
American College of Chest Physicians
911 Busse Highway
Park Ridge, Illinois 60068

American College of Physicians: regional meetings and programs as scheduled below:

- | | |
|----------------|--|
| January 5-9 | Workshop in the Physiology, Diagnosis & Treatment of Electrolyte and Acid-Base Disorders at Annenberg Auditorium, University of Pennsylvania |
| January 20-23 | Internal Medicines and the Practice of Internal Medicine, 1976 at San Francisco, California |
| January 28-30 | Infectious Diseases at Keystone, Colorado |
| January 38-30 | Update in Infectious Diseases at King of Prussia, Pennsylvania |
| February 9-11 | Basic Mechanisms of Disease at Shreveport, Louisiana |
| February 18-20 | Clinical Immunology for Physicians at Gainesville, Florida |
| March 1-5 | Specifically Treatable Diseases II at Philadelphia, PA |

For further information:

American College of Physicians,
4200 Pine Street, Philadelphia, Pa. 19104.

- January 8-February 12 "Pediatrics Perspective 1976—Infectious Diseases" at Booth Memorial Hospital, Flushing, N.Y.; 9 hours credit; contact:
Office of the Associate Dean
New York University Post-Graduate Medical School
550 First Avenue
New York, N.Y. 10016
- February 16-18 "Pulmonary Function in Health & Disease," "Pediatric Pulmonary Disease" and "Newer Concepts of Care for Patients with Respiratory Disease" at Braniff Place Hotel in New Orleans.

For more information contact:

American Thoracic Society
1740 Broadway
New York, N.Y. 10019
Attention: Mr. Ben Fontaine

- February 20-21 Koch Centennial Symposium at Hilton Hotel, Baltimore, Maryland; 16 hrs. credit.

For more information contact:

Mr. Sheldon Elman
Baltimore City Health Department
Division of Tuberculosis Control
111 N. Calvert Street, C-232
Baltimore, Maryland 21202

- February 23-28 Diving Medicine at Truk, Micronesia; fee: \$200.

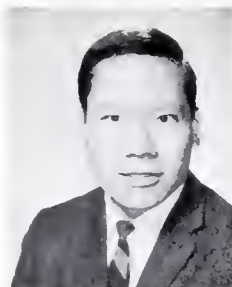
For more information contact:

University of Hawaii Conference Center
(DMC-76)
2500 Dole Street
Honolulu, HI 96822

- March 25-27 Clinical Neuro-Otolaryngology, University of Pittsburgh School of Medicine; at Eye and Ear Hospital of Pittsburgh.

For more information, write to:

Sidney N. Busis, M.D., Course Director
Eye and Ear Hospital of Pittsburgh
Pittsburgh, PA 15213



Kenneth S. Ching, M.D.

Hilo Hospital
Hilo, Hawaii 96720
ANESTHESIOLOGY



George K. T. Chung, M.D.

1448 Liliha Street
Honolulu, Hawaii 96817
CARDIO-THORACIC SURGERY



James Lee Blattau, M.D.

North Shore Clinic
Kahuku, Hawaii 96731
INTERNAL MEDICINE/
FAMILY MEDICINE



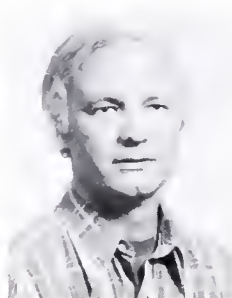
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1441 Kapiolani Boulevard
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GENERAL SURGEON



Vernon G. Boido, M.D.

86-260 Farrington Highway
Waianae, Hawaii 96792
GENERAL PRACTICE



Samuel Lawrence D'Amato, M.D.

1282 Queen Emma Street
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Benjamin N. Branch, M.D.

P.O. Box 248
Kahuku, Hawaii 96731
OB/GYN



Paul A. DeMare, M.D.

1301 Punchbowl Street
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RADIATION THERAPY



Benjamin C. Chang, M.D.

880 Kam Highway
Pearl City, Hawaii 96782
PEDIATRICS/ADOLESCENT
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263 Alexander Young Building
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1451 South King Street
Honolulu, Hawaii 96814
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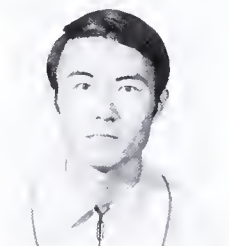
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PATHOLOGY



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PREVENTIVE MEDICINE
(International Health)



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PATHOLOGY



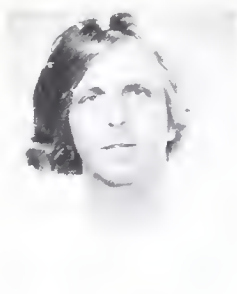
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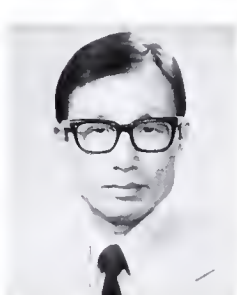
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FAMILY PRACTICE/EMERGENCY
ROOM



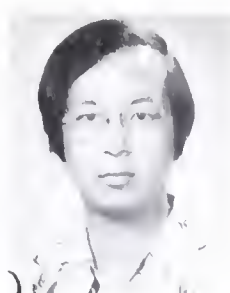
Santad Sirachainanta, M.D.

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Kealahou, Hawaii 96750
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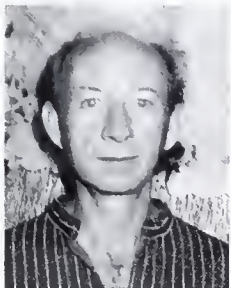
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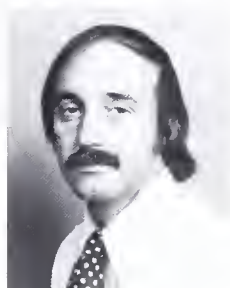
Louis Wu, M.D.

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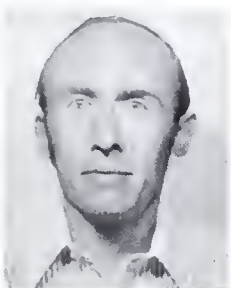
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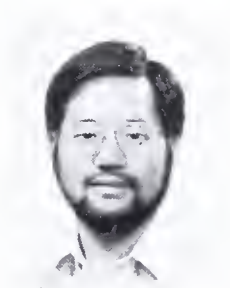
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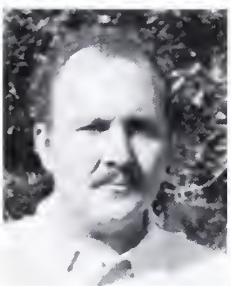
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Chiu-Hung Tsai, M.D.

45-710 Keaahala Road
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INTERNAL MEDICINE



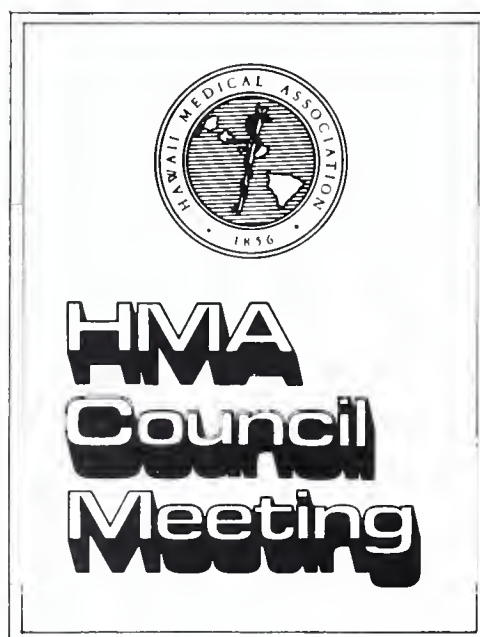
Mark Allen Wentworth, M.D.

Tripler Army Hospital Medical Center
Honolulu, Hawaii
FAMILY PRACTICE



Edmund S.M. Whang, M.D.

34 Makani Avenue
Wahiawa, Hawaii 96786
INTERNAL MEDICINE



September 26, 1975, 5:30 P. M.
Mabel Smyth Lanai

CALL TO ORDER

The meeting was called to order by President Winfred Y. Lee. Present were Drs. Dang, Sloan, Batten, Mills, Chinn, Goto, Reppun, Siensen, Edwards, Carl Lum, Catts, Lichter, Uehara, Adams, Chun-Hoon, Sia, and Mrs. Alice Tucker.

MINUTES

The minutes of the August 29, 1975 meeting were approved as circulated.

REPORT OF THE TREASURER

The financial statement for August 1975 was approved subject to audit.

The proposed budget for 1976 was present for Council review. The following actions were taken:

- (1) It was voted to approve the Common Fund ratio of 60 (HMA) — 40 (HCMS) for 1976.
- (2) It was voted to approve the proposed budget for 1976 with the following amendments:
 - a) The allocation for Auxiliary dues was increased by \$3.00 per member to offset an increase in national dues. The total amount approved for this item was \$9,300.00.
 - b) The budget for continuing medical education was changed from \$9,000 to \$12,000 in view of the proposal for mandatory continuing medical education.
 - c) The budget for Tel-Med (Public Affairs Committee) was approved at \$500.00.
 - d) It was voted to approve the request of the Fee Survey Committee to reprint the Hawaii Relative Value Studies in looseleaf notebook form and to allow \$15,000 for anticipated printing expenses.
 - e) The budget for the HAWAII MEDICAL JOURNAL was approved, however the recommendation to increase the subscription fee to \$12.00 per year failed to pass.
 - f) Action was deferred on the Finance Committee recommendation to increase membership dues asking that the House of Delegates review the entire 1976 budget prior to any action on dues.
- (3) The Finance Committee was asked to look into the appropriateness of reserves and given some consideration to actuarial projections for future dues, income and expenses for the Association.
- (4) The recommendation to agree in principle with the "Dang Plan" was deferred to the end of the agenda pending discussion of the recommendations regarding a site for the HMA-HCMS offices.
- (5) A request to include \$10,000 in the proposed budget for special travel for the Hawaii Tumor Registry failed to receive approval.

REPORTS OF THE COMMITTEES AND COMMISSIONS

A. *Ad Hoc Committee on Medical Malpractice*: The ad hoc committee on medical malpractice considered amendments to the Medical Practice Act in their review of various proposals for malpractice legislation. A complete report of the recommended changes in the act was presented for Council review.

ACTION: It was voted to approve the report of the Ad Hoc Committee on Medical Malpractice including the recommendations to add two persons to the Board of Medical Examiners who represent the legal and ecclesiastical professions and to go on record as favoring mandatory continuing medical education for relicensure.

B. *Ad Hoc Committee on Future Recommendations*: The ad hoc committee presented five options for Council's consideration: (1) No renovation of present office space; (2) Renovation of present space at Mabel Smyth Building; (3) Addition of a third floor to the Mabel Smyth Building; (4) Rent or lease office space elsewhere; (5) Build or buy own building or condo space.

ACTION: It was voted to drop options 1 and 3 and consider priority for items 2, 4, and 5. It was voted to give top priority to option 5, to build or buy own building. It was agreed that funds for this option might be raised by the "Dang Plan," a plan whereby all present and future members of the Association after practicing one year would be asked to contribute \$1,000 to the fund (mandatory contribution) which could be paid at the rate of \$10/month via a bank-check/automatic deduction plan or in a lump sum with a ten per cent

discount. Contributions would be refunded if any member in good standing moved, retired, etc. This plan would be contingent upon the advice of legal counsel and accountant.

It was voted to present option 2(b), renovation of present office space with space modifications as recommended by Architect Ossipoff, to the House of Delegates if they find option 5 is not acceptable.

It was further voted that an appropriation for improvements (Option 2(b)) be approved up to a sum of \$50,000 to be shared on a 60-40 basis up to the amount Honolulu County Medical Society can appropriate. It was noted that any furnishings would be in addition to this amount.

C. *Legislative Committee*: Dr. Goto requested permission to retain Mr. Kazuhisa Abe as legislative counsel.

ACTION: It was voted to approve the recommendation and a budget of \$7,500.00 was approved for this purpose.

NEW BUSINESS

A. *Letter from Hospital Association*: The Hospital Association of Hawaii has asked to meet with the HMA to discuss several areas of mutual concern. HMA representatives for these meetings will be: Albert Chun-Hoon, William Dang, Winfred Lee, and Mr. H. Tom Thorson.

B. *PSRO*: Dr. Lee noted that the PSRO has asked for community endorsement of the PSRO conditional grant plan.

ACTION: It was voted to endorse the plan.

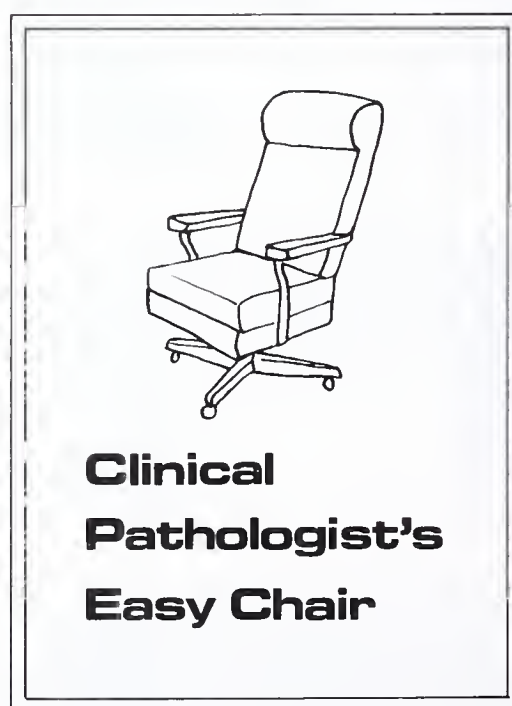
ADJOURNMENT

The Council was unanimous in commending Dr. Lee for his work as president during the past year.

The meeting adjourned at 11:45 p.m.

R. VARIAN SLOAN, M.D.

Secretary



**Clinical
Pathologist's
Easy Chair**

FRANCIS FUKUNAGA, M.D.

Osmolality

Osmolality is the solute particle concentration (osmoles) per kilogram of solvent. Its determination is of value in the clinical management of

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water and electrolyte disturbances^(1,2,3). The body regulatory system is sensitive to changes in the solute concentration, and responds to increased serum osmolality by stimulating the thirst centers and by the release of the antidiuretic hormone.

Normal serum osmolality is 285 ± 10 mOsm/Kg in men and approximately 5 to 10 mOsm less in women. Serum sodium contributes most of this total osmotic pressure, while glucose and urea add about 10 mOsm/Kg. The ratio of serum sodium to serum osmolality is between 0.43 and 0.50; the osmolality is usually over 300 mOsm/Kg when the sodium is over 150 mEq/L.

The determination of serum osmolality is particularly useful in regulating fluids in postoperative and burn patients, but is also used to follow the course of chronic renal disease, hemodialysis, nonketotic diabetic coma, hypo- and hypernatremia, uremia, hyperglycemia, hyperlipemia or increase of some undetermined molecule such as in drug overdose, poisoning and x-ray contrast media.

Serum osmolality can be estimated by calculation: $1.86 \text{ Na} + \text{glucose}/18 + \text{BUN}/2.8$. The

various factors convert each substance into moles per kg. The adjusted values are about 5 each for the glucose and BUN in normal individuals. The calculated osmolality is about 5 to 8 mOsm/Kg less than the measured. The determination of both is useful when evaluating intoxication due to alcohol, salicylates and barbiturates⁽⁵⁾. The measured value will be much higher in these circumstances, and the prognosis will be poor if it exceeds the calculated value by more than 40 mOsm/Kg.

Normal urine osmolality is 300 to 1100 mOsm/Kg, or 400 to 1600 mOsm/day. It varies widely depending upon the diet and may fall to about 200 mOsm/day in individuals on an electrolyte and protein-free diet and as high as 1700 mOsm/day when on a high protein diet. This wide variation of urine osmolality reflects the work performed by the kidneys to maintain a stable serum osmolality and is analogous to the wide normal urine and narrow blood pH ranges. The normal ratio of 24 hour urine to serum osmolality is greater than 1 and usually more than 3 following an overnight fluid restriction. However, this ratio remains about 1 in chronic renal disease and

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this is comparable to a fixed urine specific gravity of 1.010.

Urine osmolality is a much more accurate and reliable measure of renal concentration and dilution functions than the specific gravity because the kidneys respond to particle concentration (osmoles) rather than the weight of its solutes. A specific gravity of 1.020 represents a wide range of osmolality from 550 to 900 mOsm/Kg and a specific gravity of 1.010 ranges from 120 to 500 mOsm/Kg. Concentration tests normally reveal a urine to serum osmolality of over 3 and a urine osmolality of over 850 mOsm/Kg. The osmolality is 400 to 600 mOsm/Kg with moderate renal damage, and less than 400 with severe damage. It ranges from 50 to 200 mOsm/Kg and the urine-to-serum ratio is less than 1 in diabetes insipidus; it remains about the same with water restriction. Osmolality rises in psychogenic polyuria. Inappropriate ADH secretion, usually associated with poorly differentiated neoplasms such as bronchogenic carcinoma, some liver and CNS diseases, is characterized by normal renal function and BUN, serum hypo-osmolality and hyponatremia, but urine hyperosmolality and increased

urine sodium.

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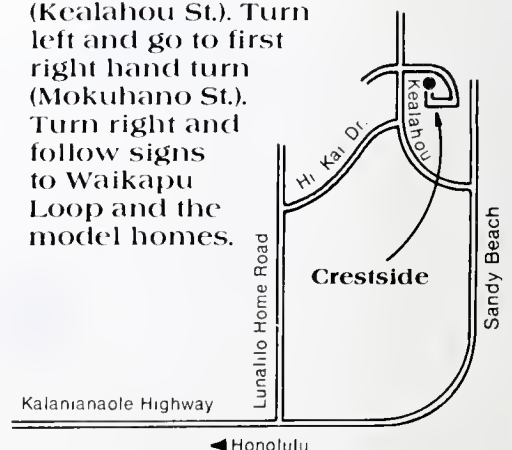
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Our “Angels”

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Maybe the patient's self-diagnosis is right. He could have hay fever. But that bright red nasal mucosa, along with the thick discharge and excoriation around the nares, strongly suggests that the main problem is a cold. Hay fever or another form of allergic rhinitis may or may not be an underlying factor.

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Whether it's a cold or an allergy, Dimetapp Extentabs® relieve stuffiness, drip and congestion.*

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INDICATIONS

Based on a review of this drug by the National Academy of Sciences — National Research Council and/or other information, FDA has classified the following indications as lacking substantial evidence of effectiveness as a fixed combination: Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses, such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.

CONTRAINDICATIONS: Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower

respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.

WARNINGS: *Use in children:* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.

PRECAUTIONS: Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihista-

mines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedatives, tranquilizers, etc.

ADVERSE REACTIONS: Adverse reactions to Dimetapp Extentabs may include hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia; drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis, CNS-depressant and (less often) stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation, and epigastric distress. **HOW SUPPLIED:** Light blue Extentabs in bottles of 100 and 500.

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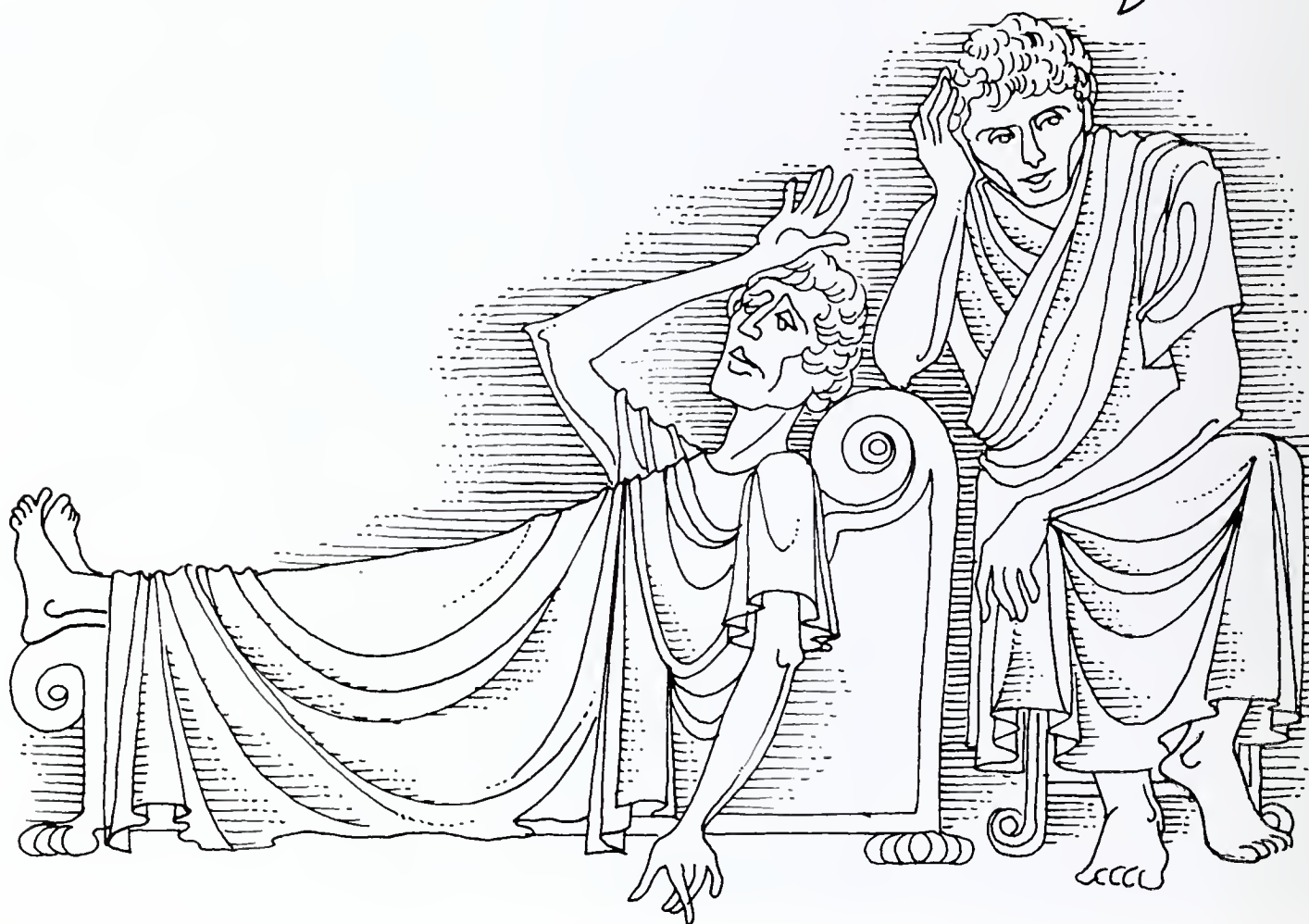
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- Associated depressive symptoms

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neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive dis-

orders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anti-convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

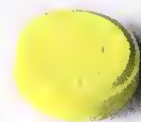
respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent

in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



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(diazepam) [Ⓢ]

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in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of child-bearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle

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